ROCKY MOUNTAIN MEDICAL JOURNAL

Title Registered U. S. Patent Office

Publication Office
835 Republic Building (1612 Tremont Place),
Denver 2, Colorado
Telephone AComa 2-0547

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August 1959, Volume 56, Number 8

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. . . . The pages that are missing were removed because they were advertisements.

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AS YOU LIKE IT...

A medical potpourri

Compiled by Andrew M. Babey, M.D., Las Cruces, New Mexico

1. "Nevertheless, it may be said without undue straining of the phrase that in a certain sense the whole of a doctor's life is passed in a medium from which the pressure of emergency is never remote. He may be described, perhaps not too extravagantly, as living to some degree like a soldier in an unfriendly country, where his whole behaviour must be alert and circumspect, and his reaction to events under careful control." The Collected Papers of Wilfred Trotter, FRCS., London, Oxford University Press, 1941, page 1.

2. "The attitude of the patient approaching his doctor must always be tinged—for the most part unconsciously—with distaste and dread; its deepest desire will tend to be comfort and relief rather than cure, and its faith and expectation will be directed towards some magical exhibition of these boons. Do not let yourselves believe that however smoothly concealed by education, by reason, and by confidential frankness these strong elements may be, they are ever in any circumstances altogether absent." Ibid., page 2.

3. "At a time when it is no longer possible to conceal the wholly unique importance of medicine for the very existence of social life, that profession finds itself of all professions the least in command of social prestige, the least privileged, the most exposed, and the hardest worked." Ibid., page 4.

4. "The practice of medicine is dangerous in a more interesting and more pressing sense than that, first, because it is so meagerly cared for by legal privilege and immunity, and secondly, because of the inherent difficulty and instability of the relation of the patient and doctor." Ibid., page 4.

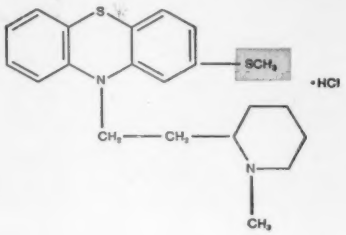
5. "It is considerations such as these that justify the statement I have made, that in a certain sense of the term the feeling of emergency can never be far from the mind of the active doctor. However disturbing that experience may be, and however much at times he may be inclined to envy the calm and prestige of more secure professions, if he is a person who prefers having a man's job to having one of the other kind, he will remember that his deficiency and his exposure are the price to be paid for that dignity." Ibid., page 5.

6. "No one can be a satisfactory craftsman who does not possess what we vaguely call a feeling for his material—an intuitive understanding of what it will resist and what it will yield to, of its grain and temper, of when it can be commanded and when it must be coaxed. The most difficult of all materials, the living body, naturally does not call for less of such sympathetic comprehension than do metal and wood and stone." Ibid., page 6.

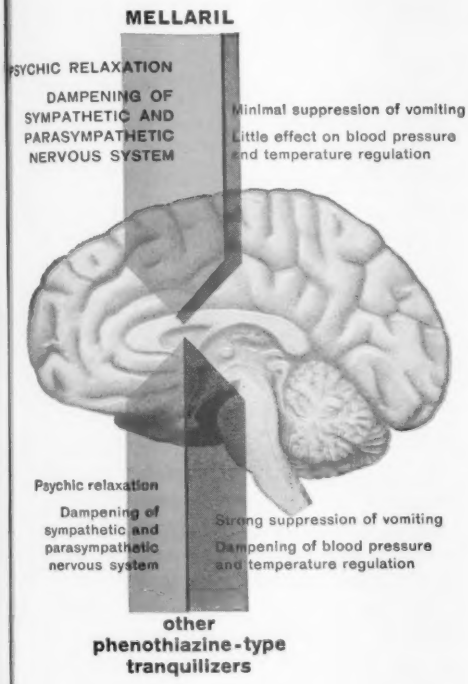
7. "In an atmosphere of urgency even simple ideas are subject to confusion, and confusion of thought inevitably leads to confusion in action." Ibid., page 8.

8. "Apart from penetrating, and presumably contaminated, wounds of the brain which are absolute emergencies, the head injuries of civil practice rarely call for urgent operation. The capacity of the brain to recover from extensive contusion and minor haemorrhages is very great; but its susceptibility to suffer gravely in this state from the further damage of an operation is no less pronounced, so that an emergency operation is a far more serious blunder than in most abdominal cases. The progressive local haemorrhage is the only condition that produces a surgical emergency. It is comparatively rare, its symptoms display an orderly development, and permit of reasoned diagnosis and rational treatment. It is thus possible to say that operation within the first 24 hours is almost always useless and dangerous, and we may add without extravagance that the very few patients who survive would have done better without it." Ibid., page 12.

a new advance in tranquilization:
greater specificity of tranquilizing action results in fewer side effects



The presence of a thiomethyl radical ($S\text{-}CH_3$) is unique in Mellaril and could be responsible for the relative absence of side effects and greater specificity of psychotherapeutic action. This is shown clinically by:



1 A specificity of action on certain brain sites in contrast to the more generalized or "diffuse" action of other phenothiazines. This is evidenced by a lack of appreciable anti-emetic effect.

2 Less "spill-over" action to other brain areas — hence, absence of undue sedation, drowsiness or autonomic nervous system disturbances.

3 A notable absence of extrapyramidal stimulation.

4 Lack of impairment of patient's normal drive and energy.

5 Virtual freedom from such toxic effects as jaundice, photosensitivity, skin eruptions, blood forming disorders.

INDICATION	USUAL STARTING DOSE	TOTAL DAILY DOSAGE RANGE
ADULTS: Mental and Emotional Disturbances:		
MILD—where anxiety, apprehension and tension are present	10 mg. t.i.d.	20-60 mg.
MODERATE—where agitation exists in psychoneuroses, alcoholism, intractable pain, senility, etc.	25 mg. t.i.d.	50-200 mg.
SEVERE—in agitated psychotic states as schizophrenia, manic depressive, toxic psychoses, etc.:		
Ambulatory	100 mg. t.i.d.	200-400 mg.
Hospitalized	100 mg. t.i.d.	200-800 mg.
CHILDREN: BEHAVIOR PROBLEMS IN CHILDREN	10 mg. t.i.d.	20-40 mg.

MELLARIL Tablets, 10 mg., 25 mg., 100 mg.

[a]Ostfeld, A. M.: Scientific Exhibit, American Academy of General Practice, San Francisco, April 6-9, 1959

SANDOZ

RADIOLOGIC REFLECTIONS

Shadow or substance

Marcus J. Smith, M.D., Santa Fe, New Mexico

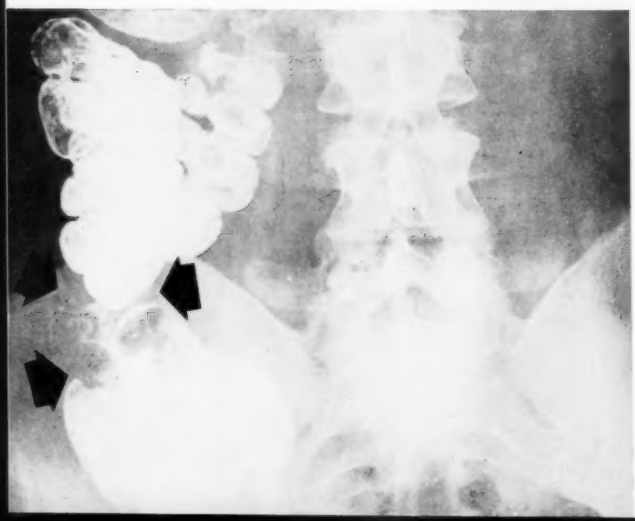
Apothegm

"It must always be borne in mind that the x-ray diagnosis is only a part of the findings in any particular case. Under some circumstances . . . it may be by far the most important diagnostic feature. . . ." (Rigler).

Clinical data

A 54-year-old craftsman told of epigastric distress, intermittent for many years, usually relieved by the drinking of milk or the taking of various antacid drugs. A current, more intense bout of upper abdominal pain stimulated the present investigation. The physical examination unveiled an asthenic individual with tenderness in the epigastrium and low grade anemia.

Fig. 1



X-ray studies

The examination of the gastrointestinal tract showed a chronic ulcer of the duodenal bulb. The film made six hours after giving barium by mouth revealed a discontinuity (Fig., arrows) in the barium column in the ascending colon. Is this a significant finding? Irregularities in the filling of the colon, when barium is given by mouth, are fairly frequent, since residual fecal material displaces the barium. Hence, interpretation of such irregularities must be cautious. Despite this, since such irregularities can be significant occasionally, the examination was carried further. A barium enema showed a filling defect in the ascending colon, and the radiologic diagnosis of carcinoma of the colon was made.

Surgical exploration disclosed a large, annular carcinoma of the ascending colon. This was resected.

Epilogue

The patient is alive and well four years later.

EDITORIALS

Ignorance, Selfishness, And Stupidity

The Colorado Chiropractic Association has circulated a dangerous letter over the signature of its Executive Secretary. They protest what they term "pressure" being exerted by Colorado health authorities on religious groups to promote the sale and application of polio vaccine. Were the epistle less ludicrous, we could find it difficult not to get boiling mad. However, letting off a bit of steam finds our safety valve still in order!

The letter was "fantastic" according to one of the ministers who gave it to us, "criminal" according to a representative of one of the drug firms that manufactures polio vaccine, "outrageous," "ridiculous," et cetera. Yes, it's a pack of lies so obvious that no one with a grain of sense appears to have been impressed. The "big lie" technic is a common one, for instance, among the Communists. Never tell a little lie, they say; the more blatantly dishonest it is, the better chance it has of being accepted—or at least raising doubts in people's minds. Fortunately, the Chiropractors aren't "masters of deceit" and their employment at the lie technic should fail miserably.

Let us dissect the Chiropractors' letter and demonstrate the falseness of their statements. Paragraph five has hidden in it the crux of their whole complaint. They want to use the "art" of chiropractic in the "control" of infantile paralysis. Control is a vague word here. It does not refer to prevention. They evince no interest in prevention of disabling disease. If they prevent polio they might have fewer crippled victims to manipulate. They can't come right out and admit the lessening incidence of polio, however; this would be admitting that vaccination does prevent polio. So they object to vaccination on religious grounds; after all, the letter is to the clergy. Use of the vaccine "must be abhorrent to the Creator," they say. Vaccination is condemned as "unnatural" because our "pure" bodies are contaminated with diseased animal cells! They must also be opposed to use of the cow and horse when by-products such as cowpox vaccine and tetanus antitoxin are recommended!

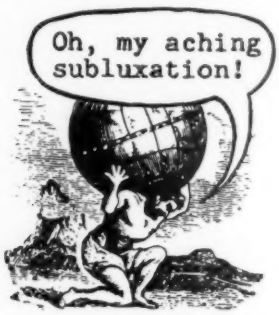
The contention that health authorities are pressuring religious groups and invading religion is ludicrous. More often the doctors of religion and medicine march arm-in-arm with one another. Yes, the clergy of Colorado were asked by us to urge their parishioners to bring their polio protection up-to-date—and they cooperated willingly. Would we do less if we were asked to urge our patients to attend church?

The most vicious words of the letter are those referring to polio vaccination as "frequently fatal" and "often deadly." These paraphrases of the same lie are transparent to the millions who have been safely vaccinated and re-vaccinated in recent years. Our "campaign to frighten the public" has obviously not been rejected. It has been well received but is far from completed. Fear of polio is not as powerful as human lethargy in a fair per cent of our delinquent populace. We are not trying to force compulsory vaccination, but have made the vaccine available, at cost or free, to all informed people who will take it for protection of themselves and their families. We are trying to eradicate one specific disease, a physically and financially disabling disease. If prevention is possible, treatment of any sort ultimately should become a pointless waste of time and money. Ignorant people making a living out of a pseudo-science selfishly appear to declare that vaccination is unneeded because they can alter the course of acute polio, somehow holding back the virus by pepping up the spine! This is reminiscent of the long outlawed carnival medicine man. There should be one more law, in our opinion, or the old one should be revised to include the contemporary mountebank.

continued on next page

Let us reprint, with thanks, part of William J. Barker's May 23 column in The Denver Post, together with the cartoon he included. We wish that all of the public were as aware of the hokum involved as is Mr. Barker:

Some rare literature has been presented in Colorado's Capitol, but Wayward will eat his hat if you can cite a rarer bit than Senator Neal Bishop's Senate Bill No. 119, providing for the licensing & regulation of chiropractors. Under "definitions" (Article 2, page 2, sec. 28-2-2 (2) it says mysteriously and majestically:



"THE TERM 'CHIROPRACTIC ADJUSTMENT' is defined as the application by hand, of adjustive force to correct subluxations, fixations, structural distortions, abnormal tensions, and disrelated structures, or to remove interference with the transmission of nerve force. The application of the dynamic adjustive thrust is designed and intended to produce and usually elicits audible and perceptible release of tensions and movement of tissues or anatomical parts for the purpose of removing or correcting interference to nerve transmission and expression."

Rather than go through all that again, next time your back aches just take a couple aspirin and lie down, o. k.?

Our back does ache, Mr. Barker, and we will take a couple of aspirins. But we can't lie down until dangerous saboteurs to medical progress and public health are rendered harmless!

It's Still Aspirin!

AMONG ALL THE DRUGS in the world, the salicylates rank among the most useful. They have been used since the time of Hippocrates, more than 2,400 years. For at least a half century, aspirin has been the most widely used drug. One monograph in the literature lists 4,000 references; we're glad we don't have to print them in this Journal!

Exploitation of acetylsalicylic acid and related substances through every advertising medium would be amusing if less nauseating. Some of our colleagues have undertaken the task of debunking contentions that addition of buffering agents, chiefly aluminum glycinate and magnesium carbonate, favorably influence the drug's speed and effectiveness. Drs. Max Sadove and Lester Schwartz at the University of Illinois College of Medicine have run a series of clinical studies upon 354 patients with undoubted real pain, under controlled conditions. Records were kept regarding onset and degree of relief, duration and side effects. Clinical and laboratory studies indicated that the effects of acetylsalicylic acid alone or with buffering agents were indistinguishable except for a two per cent higher incidence of minor gastrointestinal upsets with the buffered drug! In fact, buffering agents alone can cause intolerance and sensitivity reactions; they represent only a fraction of the minimal effective antacid dose as stated in the U. S. P. Ignoring the small question of gastrointestinal upset, we may conclude that buffering agents serve no clinically detectable useful purpose when added to acetylsalicylic acid.

Perhaps we should be pleased that such a useful drug provides sufferers the relief that it does, that it works despite added substances, and that such compounding is usually harmless—though expensive. We are tired of implied authority lent to TV and printed advertisements by the white-coated "doctor" complete with head mirror and stethoscope, plus politely stylized transparent "models" of the human stomach emitting built-in burps as the fast fast fast relief takes place.

Should we rise up in arms, or should we relax and tolerate it? The only relevant serious note sounds when we contemplate the fact that physicians are now receiving a slightly smaller segment of the health and medical dollar than they did in 1939, while ancillary workers are claiming what appears to be more than their share. With no answer forthcoming, let's be amused at the advertisers who invent a trade name by taking the "g" off of buffering, to be exploited by another who puts it back for benefit of credulous listeners who don't know the difference. And here's a suggestion to cover the whole business: Let's add an "l" and call it "bluffering"!

Presidential address*

L. Harmon Wilmoth, M.D., Lander, Wyoming

THE WYOMING STATE MEDICAL SOCIETY has had a successful and progressive year. In general, your officers, councilors, and committeemen have worked nobly. Their diligent efforts have been both constructive and productive, for which you and I owe them a deep gratitude and words of praise.

I am pleased to observe that our Society is taking on a new position of responsibility and stature in the medical Affairs of State. In a conversation with Dr. Franklin D. Yoder a year or two ago, he lamented the fact that there is a complex multitude of governmental departments which handle various phases of state medical affairs, but with no recognized medical authority available to them. The situation is changing so that, as it should be, we are being called in more and more in an advisory capacity on state medical problems. Committees of our Society have rendered commendable advice and guidance to our state government this past year on such as the tuberculosis problem, safety on the highways, mental health in which an aroused public is practically stealing the ball from us, geriatrics which is mushrooming into an overwhelming political problem, appointments to health boards, legislation in which we at least get an attentive ear even though not always heeded, school health programs, poliomyelitis, emergency medical service in civil defense, Selective Service, and others. There have been letters of appreciation from the Governor and other officials. It is certain that we are in a position to render important guidance to our state; and that our status will continue to develop if we assume our public obligations with professional ability and a sincere desire to be helpful.

Our truly great parent body, The American Medical Association, which we need to remind ourselves is merely an effective combine of our state societies, and to which we owe steadfast loyalty and support for tremendous accomplishments in our behalf, is giving major attention right now in Atlantic City to three issues.

Some problems are insoluble

The first one, regarding our attitude toward closed panel medical practice, I find to be insoluble. We are agreed that a free choice of physician is always the ideal. There are many situations in which such would be completely impractical, the Armed Forces and state institutions for example; and I believe that we will have to recognize it. There appears to be a trend in medical thinking which is gradually acknowledging that all closed-panel medical practice is not necessarily bad. For us to take a dogmatic stand against all closed-panel medical practice to the extent of depriving all offenders of their society membership would be unrealistic; for practically all of us are guilty in some aspect of our work. We should demand free choice of physician wherever it is at all possible; but I believe that is as far as we can go. Society-wide contracts such as Medicare and Home Town Veteran's Care, though not completely satisfactory, do represent a notable concession in the direction toward which we strive. I can remember when any government medical contract meant a contract surgeon, not always the most capable choice, and he received $125 a month, or less.

continued on next page

*Presented before the Wyoming State Medical Society at its 56th Annual Meeting, Jackson Lake Lodge, June 12, 1959.

Osteopaths borrow from us

Second, the osteopathic question. I have no sympathy with the expressed views of some of our colleagues who believe that we should take its practitioners into our fold. Such misguided charity is not based upon the facts as I have observed them. Regardless of claims, currently established osteopaths have rarely demonstrated that they are the equal of M.D.'s. Their education is lacking in depth. They borrow everything from the medical profession, and some of them barge into fields beyond their capacity. Throughout the years we have relentlessly and critically guarded against professional inferiority amongst our own members. It is a part of our doctor responsibility to the public; and we are failing in our duty if we do not resist the encroachment of inadequately qualified people into the healing arts and sciences. There are ample grounds for a firm stand against them. The biggest argument of all, to me, is that not a single one of our great universities, centers of learning with access to all of the knowledge of the world, and presumed to be impartial, considers osteopathy of sufficient merit to place its teaching on its curriculum. We should not hesitate to let the public know these facts.

Flight from responsibility

Third, Social Security. I simply cannot comprehend the frame of mind of a person who will voluntarily and with his eyes open go for governmental social security. There is such overwhelming evidence on every hand that the government bureaucrats cannot run anything, I mean anything without a terrific loss of efficiency, scandalously excessive cost, and an awesome volume of regulations and reports. For myself, I want to enjoy the wholesome satisfaction of providing for my own old age through a free choice of my efforts, savings, and investments; but my opposition to the whole philosophy of governmental wet-nursing goes far deeper. I fear socialism like drug addiction. Such a program threatens the financial stability and the very life of our country. It is wrecking the good old staunch and independent moral fiber of our people. I have voluntarily spent near six years in the armed services in two world wars plus 20 years in the Reserve Corps for purely a deep, and I hope not obsolete, sense of patriotism. To now join the clamoring forces which are selfishly disregarding the security of our country, even unwittingly trying to destroy it, would be inconsistent and—in my opinion—the very opposite of patriotism. We doctors have been intelligent enough to see the light, or more correctly the dark, toward which the massive forces of socialism are leading us. We have waged a truly noble fight to stave off socialized medicine. We are now the last surviving group against the moral decay of social security. Perhaps we will lose the battle; yet, may I remind you, many a war has been won by losing all of the battles but the last one. I say that we cannot, in good conscience, surrender. It is my prayer that we will continue to stand firmly as a ray of guiding light for the many who have been deluded by the misconception that the government is a womb of infinite capacity in the haven of which all may escape their worldly responsibilities. I wish to stand up with Mal Rumph, President of the Association of American Physicians and Surgeons, the valiantly fighting organization to which every one of you should belong, and shout forth his powerful message: "Our greatest psychic disturbance is the flight from responsibility. This aberration of the intellect has spread like an infectious plague over our entire land, attacking people in every phase of society. Tranquilizers are the symbol of the era." I say that we doctors are ethically bound to resist this disease, rather than to spread it.

Wash our own dirty linen

In closing, I wish to comment upon that ever-present and inescapable thorn, Public Relations! I get the impression that there has been a continuing deterioration in the grand old revered, father-confessor, kingpin-in-the-community status of doctors. This is in spite of organized and carefully studied efforts to improve our standing. There are some understandable reasons for it. Many doctors persist in feeling that they have to have the swankiest car and home in the neighborhood. Such is not noted for winning friends amongst the less favored public. Doctors are seemingly an arrogant bunch of

dictators who order people around. The merchant has a saving device to avoid customer clashes by his motto: "The customer is always right"; but this is denied the doctor, who must regularly tell the customer-patient that he is wrong. We must study the worthy example of our pharmaceutical colleagues for ways to make our restrictive and bitter administrations more palatable. The human is a sensitive being.

There are too many instances of unfriendliness between doctors, which help no one, and do us all harm. Some doctors, with reckless disregard of the boomerang effect, either subtly or bare-faced, drag down and lower the faith of the public in fellow doctors. I honestly believe that the boisterous Dr. Paul R. Hawley should be painlessly eased out, and that the American College of Surgeons is guilty in not silencing him. True, the medical profession has some dirty linen which requires cleaning, and we must face the responsibility within our own closed doors; but it seems obvious to me that public airing, and the consequent destruction of public confidence in the medical profession is not the solution. It has been repeatedly shown that the bad actors constitute a very minute minority.

Doctors are outraged when patients have the temerity to change to another doctor. It is aggravating to have them be so indiscriminating, but we all have to face it! We are obliged to stand up for their right to do so, and we were probably too busy to give them full attention anyway; so let's smolder over it in private and not antagonize everybody by making a public spectacle of our feelings. A disloyal patient is not worth lamenting.

In these days of critical appraisal of higher medical costs by the public, many doctors are not putting out a dollar's worth of service for a dollar. How often one hears the comment from a surprised patient: "In all of the times I have been to a doctor, I have never had a thorough examination like this." The inference is not complimentary. Or, certain doctors "never tell me a thing." For what they are being charged, people are entitled to be told; and we doctors have to take the time to tell them, willingly, in their language. The terrific boom in lay medical writing reveals that they think they are entitled to medical information; and it is wiser for us to be their instructors rather than lay medical writers.

Do doctors really have to be so outrageously individualistic, I wonder? You take any ten doctors on almost any subject, and you get ten different ideas, each doctor contentiously defending his stand as being the only right one. Sparks fly. We behave more like a bunch of brothers than like a brotherhood. Since such a show of disparity is, on the very face of it, not supportable by the facts or sound reasoning, is it any wonder that the lay public is sometimes skeptical of our profession? I believe that we could all learn to practice a more charitable understanding and earnest consideration of opposing viewpoints.

Why do I bother to rehash all of these well known points to a group of doctors? I'll tell you why. It is because I continue to find evidences that doctors forget them! •

New officers named by World Medical Association

At the Twelfth Annual Meeting of the Board of Directors of the World Medical Association, United States Committee, Inc., the following officers were re-elected for 1959-1960: Chairman, Dr. Austin Smith, President, Pharmaceutical Manufacturers Association; Vice Chairman, Mr. H. J. Loynd, President, Parke Davis & Company; Secretary-Treasurer, Dr. Louis H. Bauer, Secretary General, The World Medical Association. Mr. H. S. McNeil, President, McNeil Laboratories, Inc., was unanimously elected to serve as Director for the term of 1959-1962.

The Board of Directors also established an Honorary Board Membership classification and Mr. Robert Lincoln McNeil, Chairman of the Board of McNeil Laboratories, Inc., and a member of the Board of Directors of The World Medical Association, United States Committee, Inc., since its organization in 1948, was unanimously elected the first Honorary Board Member in recognition of his distinguished service.

Reticulum cell sarcoma presenting in the testis

Two rare cases

Brodie C. Nalle, Jr., M.D., Colorado Springs, Colorado

THE TWO REPORTED CASES were consecutive at a single hospital and seen by one physician. The mathematical chances of such happenings defies the imagination, as evidenced by review of the literature. Nongerminal tumors of the testis occur around the 3 per cent level in most classifications, which differentiate the above from the four main germinal tumors: (a) seminoma; (b) embryonal carcinoma; (c) teratocarcinoma, and (d) choriocarcinoma. Of all testicular tumors, reticulum cell sarcoma occurs at the 0.1 to 0.3 per cent level.

A review of the literature reveals that malignant lymphoma with early manifestations in the testis is unusual and that primary lymphoma of the testis is very rare. Melicow[1] in 1955 reviewed multiple cases of testicular tumors at the Presbyterian Hospital of Columbia University over a period of 25 years. He found 105 cases of apparently primary malignant tumor in the testis, and 13 cases of metastatic tumor in adults. In children there were three primary malignancies and four metastatic. Out of the 13 metastatic tumors in adults, four were reticulum cell sarcoma and four were lymphosarcoma. In children, of the four metastatic tumors, two were in the lymphoma group. This shows the infrequency of metastatic tumors of the testis and, in most cases, clinically the tumor is (or was) suspected as being seminoma. The age range in the adult cases was 39 to 67 years with the majority over 50 years.

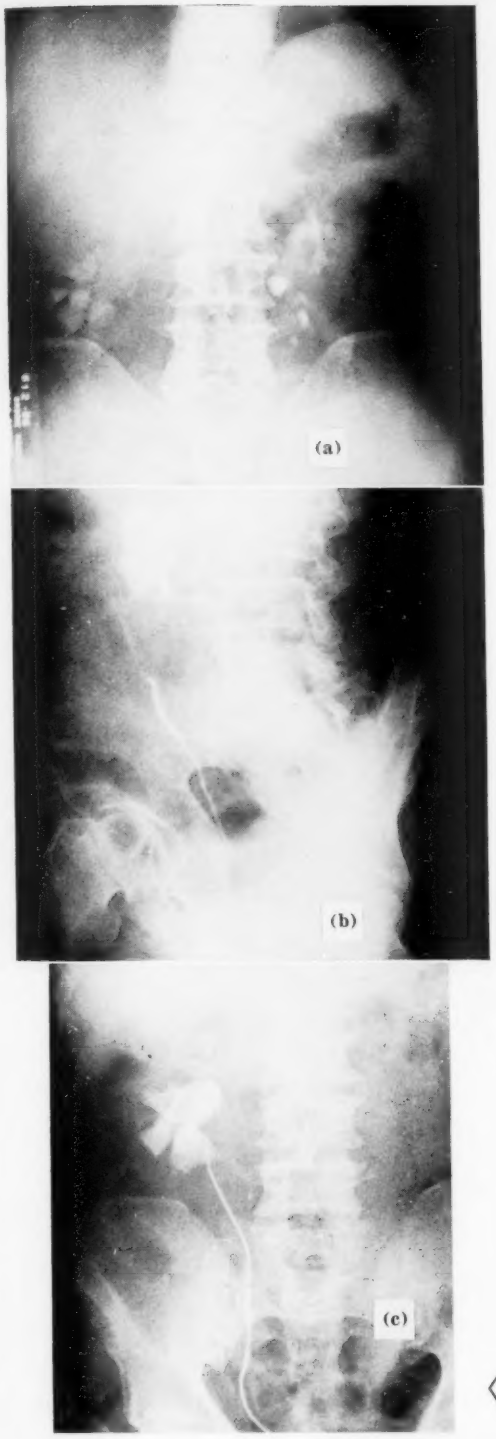
Between 1877 and 1955 Varray[2] found only 30 cases of lymphoma of the testis reported in the literature of America and Great Britain. In 1942 Dockerty[3] found only four lymphomas among 400 testicular tumors at the Mayo Clinic. These were all described as small round cell type. Of all the metastatic tumors which occur in the testis, lymphosarcoma is the most common. Watson[4], et al., in 1949, in reviewing a series of 1,073 lymphomas, found 456 lymphosarcomas of which 75 invaded the genito-urinary tract and two of these were present in the testis. Watson added five cases to this number. Of tumors which occur bilaterally in the testes, lymphosarcoma is the most frequent.

In 1955 Hotchkiss[5] collected 21 cases of concomitant bilateral malignant testicular tumors from the literature since 1805. His own case was diagnosed reticulum cell sarcoma of both undescended testes. In 1955 Cohen, et al.[6], presented four cases of reticulum cell sarcoma with primary manifestation in the testis. Of 2,860 cases of testicular tumor, in the literature in the past 10 years, only six were reticulum cell sarcoma.

Thus, in summary of the literature, one can state that of metastatic tumors which occur in the testes, lymphosarcoma is the most frequent. The purpose of this paper is to add two more cases to the literature—one of multicentric origin, the other of apparent localized origin, and both occurring primarily in the testes.

CLINICAL SUMMARIES

Case 1. This 69-year-old man was first admitted on June 26, 1956, with the complaints of right flank pain and painful testis of two weeks' dura-



tion. Past history revealed that in 1916 he suffered a fall, after which he had urethral bleeding for several days. Twice in the past 10 years he had ureteral colic and passed stones. The pain was located on the right. Nocturia two to five times. Physical examination showed congenital phimosis and ureteral stricture. There was right flank tenderness and a palpable mass in the right upper quadrant. The right testis was enlarged, soft and tender; the left, atrophied. Excretory urogram showed ptosis of the right kidney with malrotation of the right and left calyceal components. There was dilation of the right renal pelvis and right calcyceal components. The right ureter was narrowed in its proximal one-third. Left pyelograms were within normal limits. There was anterior displacement of the left ureter. Urologic examination was done on June 26, 1956, at which time cystoscopy and retrograde pyelograms were done.

Diagnosis: 1. Ureteral stricture, traumatic; 2. benign prostatic hypertrophy; 3. right renal tumor; 4. horseshoe kidney.

The right testis was removed and recovery was uneventful. The local pathologist believed that the tumor was a reticulum cell sarcoma, as did Dr. Nathan Freedman of Los Angeles. Drs. Lawrence Ackerman of St. Louis and Arnold Rich of Baltimore thought that the tumor might be a granulomatous orchitis. The patient refused any other therapy.

On September 16, 1956, the patient was readmitted complaining of right upper quadrant pain of three months' duration. X-ray showed a stone in the gallbladder. Elective cholecystectomy was planned. Other findings were chronic cough and emphysema, dyspnea, weight loss and fatty food intolerance. Laparotomy was done on September 18. A large retroperitoneal mass was found in the area of the right kidney. This was nodular in nature and there were also nodules palpated along the right iliac vessels. Biopsy of the retroperitoneal mass was taken and the abdomen was closed. Soon after midnight, the day of operation, the patient took a sudden turn for the worse and expired at 1:05 a.m. Autopsy was done.

Anatomical Diagnoses: 1. Surgical absence of the right testis; 2. horseshoe kidney with double ureter, left; single on right; 3. reticulum cell sarcoma, left testis, periaortic nodes, right kidney, both adrenals, lungs, pancreas, mediastinal and mesenteric nodes. The urinary bladder was also involved around the ureteral orifices by the lymphoma; 4. Advanced arteriosclerosis with aneurysm of the common iliacs; and 5. moderate emphysema.

N.B.—Microscopic slides from the remaining

Fig. 1. (a) Ptotic right kidney with caliectasis of lower segment; malrotation, left, with axis deviation (X.U.). (b) and (c) Lateral and AP showing anterior displacement of right ureter (retro).

testis, retroperitoneal mass, and autopsy were examined by Dr. Rich, who agreed now that this was a reticulum cell sarcoma.

Case 2. A 63-year-old mechanic who noticed an enlarging right scrotal mass of two months' duration starting from a small nodule about the size of an acorn, increasing in two months to a nodular hard mass measuring 7 x 6 x 4.5 cm. No redness, heat with chills or fever were noted. Denied VD or familial disease. Nocturia, two to three times. Past history revealed a right scrotal injury with hemorrhage at age 15. At age 48 injury to the left kidney, also with bleeding upon urination. Physical findings limited to the scrotum.

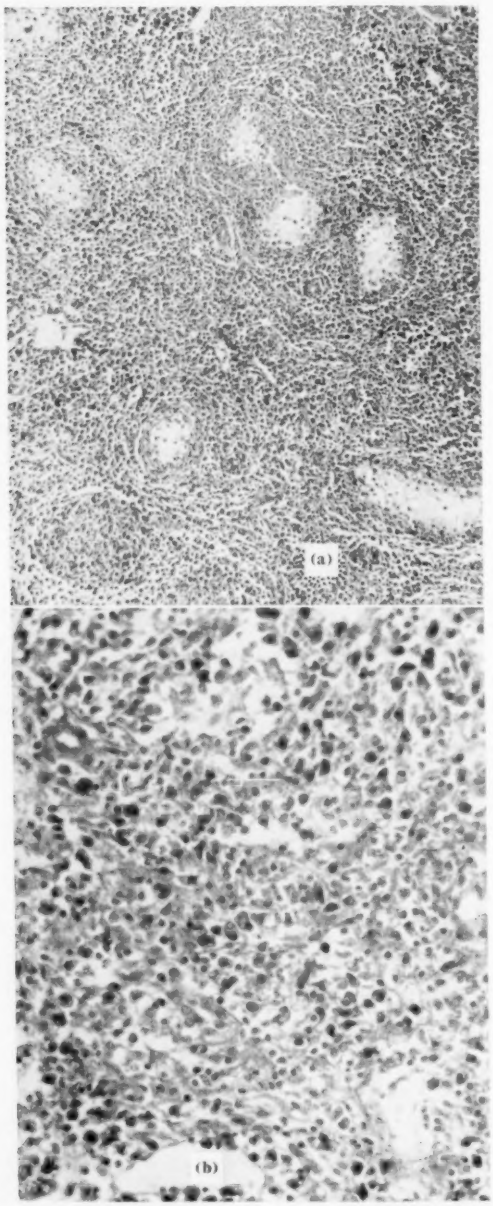


Fig. 2. (a) Case 1—low power photomicrograph. (b) Case 1—high power photomicrograph.

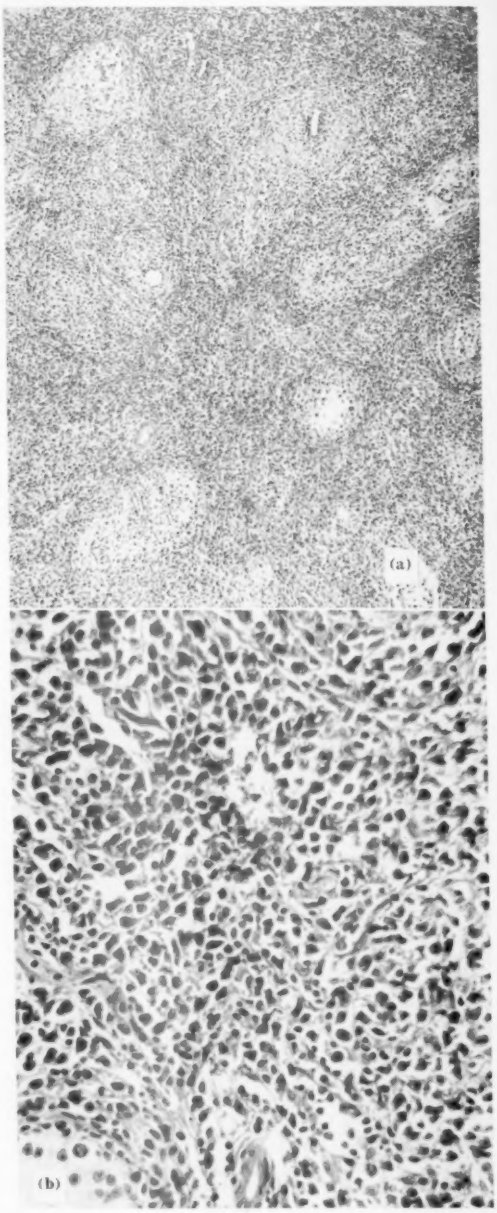


Fig. 3. (a) Case 2—low power photomicrograph. (b) Case 2—high power photomicrograph.

The right side showed an irregular hard mass measuring 7 x 6 x 4.5 cm. Right radical orchiectomy was done on November 26, 1956.

Diagnosis: Reticulum cell sarcoma of the testis. X-ray survey revealed no metastases. At the present time patient eating well, has gained 10 pounds over his usual weight of 160. X-rays of the chest have been taken every three months since the operation to August, 1958, and no metastatic lesions have been seen. Patient has received courses of deep radiation therapy to the retroperitoneal tissues. Recently the patient underwent transurethral surgery for prostatic obstruction. At this time no metastatic lesions were noted.

Discussion

The two reported cases may suggest that the testicular lymphomas were either of multicentric origin (Case 1), or localized involvement (Case 2), even though both cases exemplify enlargement of the testis as the initial sign of disease. The above question is a moot one. Some claim that most lymphoid tumors are generalized from their onset. Others believe that all lymphomas arise in one location and metastasize as do other tumors. It may not be proper, therefore, to consider a reticulum cell sarcoma as primary in the testicle until a five-year cure has been effected although still others would claim that disease appearing elsewhere was metastatic from the original tumor.

Willis[7] has done much to simplify the chaotic classification of tumors of lymphoid tissue—his premise being that all tumors of lymphoid tissue are related variants of one disease rather than the predominant cell type in the multistages of development. Reticulum cells from primitive mesoderm are present in essentially all organs and tissues, particularly in lymph glands, spleen, bone marrow, liver, skin, kidney, lung, ovaries, and testes. The predominant cell type of the tumors in both reported cases was of this nature.

Summary

Two cases of enlargement of the testicle as the presenting complaint have proved to be reticulum cell sarcoma of the testis. One was a manifestation of a generalized disease; the other was apparently a solitary testicular tumor. •

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Chlorothiazide (Diuril) in practice*

M. A. Gold, M.D., Butte, Montana

Not a panacea for all cases of edema, this drug did show excellent results in a study of 130 patients.

CHLOROTHIAZIDE (6-chloro-7-sulfamyl-1, 2, 4-benzothiadiazine-1, 1-dioxide) has been reported to be a non-mercurial diuretic agent of low toxicity that is well absorbed by the oral route, effective in a daily dose of 500-2,000 mgm. and having no loss of diuretic effectiveness with repeated daily doses. It has also been reported as potentiating the antihypertensive effects of other antihypertensive drugs, and of being of value in the treatment of premenstrual tension, toxemia of pregnancy, and possibly in the edema associated with steroid therapy.

Chlorothiazide is a sulfamyl compound but appears to have a different mode of action than other known diuretic agents. It is not potentiated by ammonium chloride, it is effective after the development of hypochloremic alkalosis, and its effects have been additive to those of mercurials or carbonic anhydrase inhibitors. It increases the renal excretion of chloride, sodium and, to a lesser extent, potassium, presumably by partial blockage of renal tubular reabsorption. It produces its effect in two hours after oral administration and the effects last for ap-

*Presented at the Regional Meeting of the American College of Physicians, Casper, Wyoming, October 11, 1958.

proximately 12 hours. In view of these reports of its effectiveness, the following investigation was begun in December, 1957.

Methods and material

Patients were those seen in the usual practice limited to internal medicine. At the beginning of this study all patients were hospitalized and adequate laboratory and clinical studies obtained before, during, and after the administration of chlorothiazide. In all hypertensive edematous patients this included chest x-rays, daily weights, intake and output, electrocardiograms, eye ground examination, serum electrolyte studies including sodium, potassium, chlorides and others if needed, blood counts, urinalysis, blood urea nitrogen and, in certain indicated cases, excretory urographic examinations. Other indicated laboratory procedures were done. These patients were all given a diet containing less than 400 mgm. sodium and unlimited fluids. Hypertensive patients were observed until blood pressures remained stabilized and then given chlorothiazide in doses ranging from 250 mgm. to 2,000 mgm. daily. Single doses were given at 7 a.m. and divided doses at 7 a.m. and 2 p.m. If no effect on the blood pressure was noted after a minimum period of four days, other antihypertensive drugs such as rauwolfia, veratrum, or one of the ganglionic blocking agents (pentolinium) were added in that order. Hydralazine was used in only three patients, none of whom showed any noticeable effect to any drug or combination of drugs.

Patients with cardiac edema were digitalized with Cedilanid D within 24 hours if not previously on digitalis. If edema was still present, if the patient did not show a loss in weight, and urinary output was not greater than fluid intake after an additional 48 hours, a mercurial diuretic was given. After an additional 48 hours, chlorothiazide was given orally in doses ranging from 250 mgm. to 2,000 mgm. once or twice daily. Patients with edema due to nephritis or cirrhosis were given a minimum period of four days of observation and water balance before chlorothiazide was begun.

After familiarity with the effects of the drug was obtained, some of the patients in the hypertensive group, a few of the patients with mild cardiac edema, and all of the patients with other conditions were treated on an outpatient basis but standards of diagnosis, necessary laboratory and clinical studies were not relaxed. The use of mercurial diuretics was omitted in the last 15 cases of edema and chlorothiazide was used instead. Patients have been on chlorothiazide from one to ten months. Ages ranged from 16 to 88 years.

Because of the possibility of producing a hypokalemia with long continued administration of chlorothiazide, all patients on long-term therapy are given supplemental potassium. Hypertensives are now given regular, normal sodium diet with supplemental potassium unless weight loss is desired, in which case a restricted calorie diet is given.

The indication for chlorothiazide overlapped in some patients; for example, some hypertensives had cardiac decompensation and the basic reason for use of chlorothiazide was the edema. However, the main indication for the use of chlorothiazide determined the classification of the case and no case is listed in more than one category (Table 1).

The hypertensive cases were arbitrarily classified into mild, moderate, and severe. Mild cases were those whose systolic pressure was not above 180 mm. of mercury and diastolic not over 100, the limits for moderate pressure were 200 systolic and 110 diastolic and those for severe pressure were over 220 systolic and 120 diastolic. If only the systolic or diastolic pressure were over the limit set,

TABLE 1
Classification of patients

Indication	Number of Patients
Hypertension	61
Edema	
Cardiac	32
Nephritic	12
Cirrhotic	6
Steroid	2
Obesity	3
Premenstrual tension	10
Glaucoma	2
Hypothyroid	2
Total	130

TABLE 2

Results in hypertension

Average decrease in blood pressure from pretreatment level

	Chlorothiazide alone	Chlorothiazide plus other antihypertensive drug
Severe	30/18 (14.5%)	46/22 (19 %)
Moderate	26/12 (12 %)	34/18 (16.5%)
Mild	18/6 (8 %)	22/12 (12 %)
Average	25/12 (11.5%)	34/17 (15.5%)

TABLE 3

Cases not responsive

	Chlorathiazide alone		Chlorothiazide plus other antihypertensive drug	
	Hypertensive Cases	Not Responsive	Hypertensive Cases	Not Responsive
Severe	6	2	14	2
Moderate	15	5	23	1
Mild	5	2	7	0
	—	–	—	–
Total	26	9	44	3

the case was considered as belonging to the lower group; if both were over the limit it was placed in the higher group.

Hypertensives and cardiacs

Results in hypertension: Table 2 indicates the results in hypertension. An average drop of 11.5 per cent in blood pressure occurred in hypertensive cases with the use of chlorothiazide alone and an average drop of 15.5 per cent in blood pressure when chlorothiazide was used in conjunction with other antihypertensive agents.

An average drop of blood pressure of 11 per cent on antihypertensive drugs other than chlorothiazide has been reported, so that chlorothiazide alone is comparable to the average antihypertensive drug or combinations of drugs and, in this study, additionally valuable with other drugs. Table 3 shows the cases considered not responsive to chlorothiazide, i.e., less than 10 per cent drop in blood pressure from the pretreatment level.

Results in edema of cardiac origin: Thirty-two cases of cardiac decompensation were given chlorothiazide in addition to usual therapeutic measures with the exception of one case which will be discussed later. Results were considered adequate if urinary output equalled or exceeded that produced by the mercurial diuretic or if no mercurial diuretic had been given, increased urinary output and weight loss occurred as compared to the previous 48 hours.

Results were considered adequate in 29 cases of cardiac edema. Of the four failures, three patients were in terminal stages of congestive heart failure with edema and resistant to all previously tried agents including courses of ACTH. These three patients all had serum sodium values of under 120 mEq. which was unable to be elevated by any means. One patient responded only to combined therapy with chlorothiazide in doses of 2,000 mgm. daily and simultaneous injection of 2 ml. of meralluride intramuscularly, although previously resistant to use of meralluride alone.

One case, a 34-year-old male miner, had had a mild upper respiratory infection which responded to antibiotics. Within 48 hours after his temperature was normal, he developed tachycardia, dyspnea, rales in both bases, an enlarged liver and edema of both legs. He was given 500 mgm. of chlorothiazide and within two hours was urinating almost continuously. His heart rate dropped from 120 to 88.

Because of this marked response, he was not digitalized but another dose of chlorothiazide was given six hours later. His urinary output for the first 24 hours was 8,700 ml. and 4,200 ml. the second day and his weight went from 166 pounds to 151 pounds in 24 hours and to 148 pounds, his usual weight, the following day without any further medication. Heart rate remained under 80, the dyspnea disappeared, the liver became normal in size and all evidence of edema cleared. He has had no recurrence of signs of decompensation, and no evidence of heart or any other disease for the past three months and is working full time as a miner. In spite of the results in this case I am still treating cardiac decompensation with digitalis first and giving chlorothiazide next.

continued on next page

Other conditions

Results in nephritic edema: Twelve cases of glomerulonephritis were treated with chlorothiazide. Eight cases, of which two were acute glomerulonephritis with edema, five were chronic glomerulonephritis and one was a diabetic with Kimmelstiel-Wilson Syndrome, responded with increased urinary output and weight loss and have been maintained on chlorothiazide for periods up to nine months. Four cases showed no response to chlorothiazide or any diuretic agent.

Results in cirrhotic edema: Six cases of edema due to cirrhosis were treated with chlorothiazide. One of two patients with moderate edema responded temporarily and the other has required no further chlorothiazide. One patient, who has had over 100 paracenteses and has had over 1,000,000 ml. of fluid removed, showed no effect. She has been resistant to all diuretics. Three patients developed drowsiness, tremors, mental confusion and coma, terminating in death in two cases. These cases are considered failures in therapy, even though they were far advanced cases of cirrhosis.

Results in steroid edema: Two cases of edema due to steroid therapy were treated with chlorothiazide. In both cases, continuation of therapy with steroids was necessary because of disseminated lupus erythematosus in one case and a marked exfoliative dermatitis in the other. Both cases have shown immediate relapse when steroids are discontinued and are being maintained on triamcinolone in small doses. The case of disseminated lupus showed an immediate response to chlorothiazide in doses of 500 mgm. once daily, losing eight pounds the first week, and now shows no edema. She is maintained on one 500 mgm. tablet of chlorothiazide once or twice weekly.

The exfoliative dermatitis showed no response even in doses up to 2,000 mgm. daily for one week. The edema may be partly due to the skin manifestation, since many of these cases do have dependent edema.

Results in obesity: Three cases of obesity with no other demonstrable cause of edema of the lower extremities were treated with chlorothiazide in addition to dietary restriction. Two of the cases have shown a continued weight loss and disappearance of the edema on doses of 500 mgm. of chlorothiazide three times weekly. The other case showed no effect on the edema although she has lost 32 pounds in weight in six months. She has been given chlorothiazide on four separate occasions for seven days at a time, in doses up to 2,000 mgm. daily, without any demonstrable change in measurements or in the edema of the legs.

Results in other uses: Premenstrual tension—admittedly the results in this condition are difficult to evaluate but eight of ten patients to whom chlorothiazide was given without any other medication, to use during the week prior to the expected menses, have continued their therapy and their statements range from "it helps" to "it's marvellous." Dosage used was 500 mgm. once daily for five days prior to the expected menses. The two failures stated they received no relief even though dosage was increased to tolerance and they developed headaches and dizziness.

Glaucoma—two patients were given chlorothiazide, 500 mgm. four times daily, for acute glaucoma, in addition to other therapy and under the supervision of an ophthalmologist. There was no demonstrable relief or any effect upon the course of the disease.

Hypothyroidism—two cases of hypothyroidism were given chlorothiazide in addition to thyroid. Both cases had pitting edema of the lower extremities. One case with BMR of −26 per cent and PBI of 2.3 mcg. per cent had been unable to lose leg edema even on restricted diet, adequate thyroid and general weight loss. Chlorothiazide in doses of 500 mgm. daily for ten days caused a reduction of 4 cm. in size of both legs at the ankle and an additional weight loss of four pounds. Further doses of chlorothiazide have produced no effect.

The second case with BMR of −21 per cent and PBI of 2.5 mcg. per cent also had persistant pitting edema of both lower legs. She still has it even though doses of 2,000 mgm. daily were given for two weeks.

Toxic effects

Minor toxic effects such as headache, weakness, nausea, vomiting, leg cramps and diarrhea occurred in a total of 12 patients.

None of the minor toxic effects necessitated discontinuing chlorothiazide. Tremors, delirium and coma occurred in three patients who were far advanced cirrhotics with death in two patients. The drug may or may not have hastened death.

Summary

Chlorothiazide is an effective, non-mercurial, oral diuretic. In hypertensives it has produced an average drop in blood pressure of 11.5 per cent when used alone and an average drop in blood pressure of 15.5 per cent when used in conjunction with other antihypertensive drugs.

In edema of cardiac origin, it has produced more than an adequate diuretic effect in 29 of 32 cases, it has been of value in edema due to nephritis and of less value in edema due to cirrhosis. It has also been used in edema due to steroids, obesity and hypothyroidism but the number of cases has been small and no conclusions have been made. Chlorothiazide has been used in premenstrual tension with good results, and it has been used without any effect in two cases of glaucoma. From this study, we conclude that chlorothiazide* is a valuable addition to the armamentarium of the physician. •

*The chlorothiazide (Diuril) used in this study was furnished through the courtesy of John R. Beem, M.D., of the Merck, Sharp and Dohme Research Laboratories. References are not included because of space limitations.

Opacification of gallstones*

E. Salzman, M.D., R. P. Spurck, M.D., L. C. Kier, Ph.D., and D. H. Watkins, M.D., Denver

When gallstones are not naturally radio-opaque, they may sometimes be made so by four days of Telepaque, one gram tid.

GALLSTONES MAY BE DEMONSTRATED radiographically as filling defects in contrast filled biliary structures by the density of their calcium content and, rarely, by the presence of gas-containing fissures or the radiolucency of their cholesterol content. This report describes an additional sign, the opacification of biliary calculi after prolonged administration of cholecystographic contrast media.

Theander[1] has reported an unproven case of this phenomenon. We have reported proven cases of opacifying gallstones[2] with in vitro reproduction of the opacification[3].

*From the Divisions of Radiology, Pathology, and Surgery, Denver General Hospital and the University of Colorado School of Medicine. Read at the Annual Session of the Colorado State Medical Society, Colorado Springs, September 24-27, 1958.

This investigation was supported in part by a research grant, A-2944, from the Division of Arthritis & Metabolic Diseases, U.S.P.H.S.

Technic of four-day test

The condition of prolonged exposure of the biliary stones to cholecystographic contrast medium is fulfilled with the "four-day Telepaque test." The patient is placed on a four-day regimen of 3 grams of Telepaque per day, 1 gram after each meal. A low fat diet is observed during the interval. The x-ray examination is made on the morning of the fifth day, the patient fasting.

The opacified biliary calculi may be identified radiographically by their over-all increase in density and linear density outlining the periphery of the stones (Figs. 1A, 1B, 2A and 2B). Frequently the opacification of the stones is quite faint and may be identified only by close scrutiny of the films. In most instances of gall bladder calculus opacification, the gall bladder has been faintly visualized. When the calculi in the bile ducts have been opacified the ducts usually have not been visualized. After completion of the four-day Telepaque test, the opacification of the stones persists for a variable period of time ranging from 2 to 14 days, gradually fading to complete disappearance. continued on next page

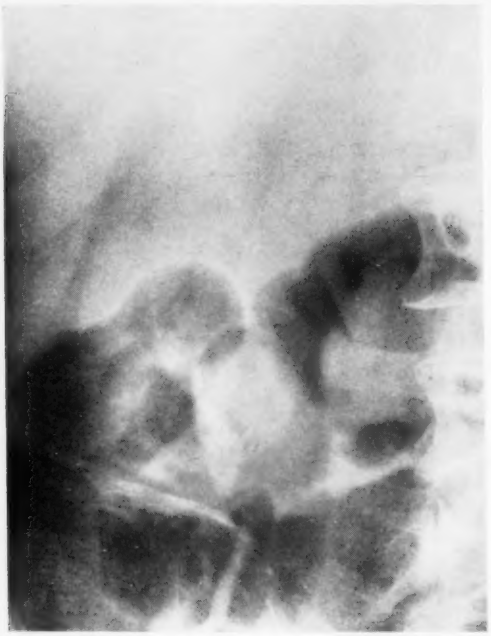

Fig. 1A. After one-day 3 gram Telepaque test: No visualization of biliary structures.

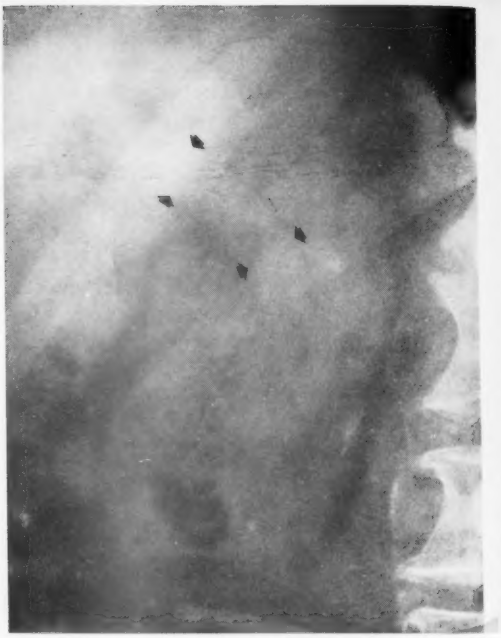

Fig. 2A. After one-day 3 gram Telepaque test: Faint visualization of dilated common duct.

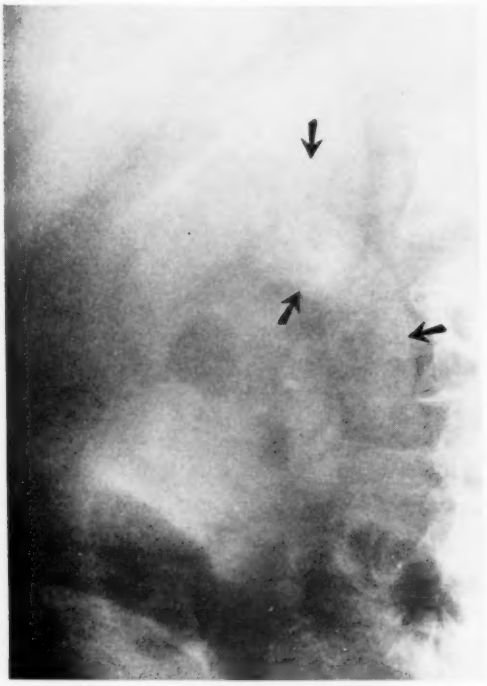

Fig. 1B. After four-day Telepaque test: Opacification of large duct stones filling the major bile ducts.

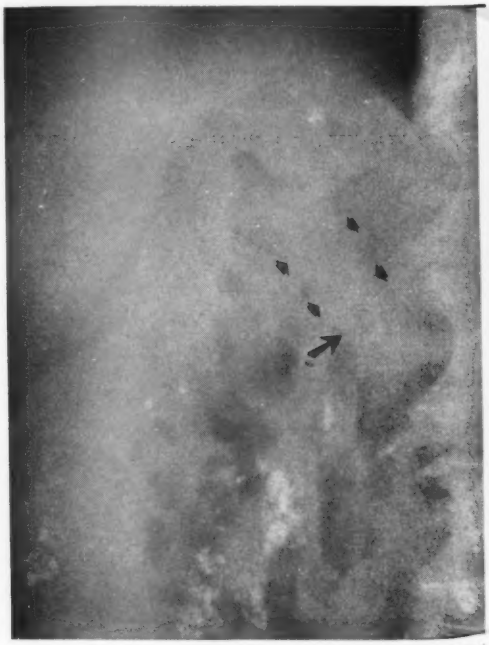

Fig. 2B. After four-day Telepaque test: Faint opacification of solitary bile duct stone (large arrow) and faint visualization of dilated common duct (small arrow).

Results

Our experience with the four-day Telepaque test in over 100 cases[4] of initial faint or no gall bladder visualizations after the conventional 3-gram Telepaque test has indicated that the test is well tolerated; diarrhea in some patients can be controlled with paregoric. The test is most useful in identifying bile duct calculi, the vast majority of which are opacifying. The test is, probably, the best available method to demonstrate bile duct stones in the presence of slight or moderate jaundice where Cholografin (Sodium Iodipamide; Squibb) cholangiograms usually fail to visualize the bile ducts[5]. The test has failed to identify bile duct stones in the markedly jaundiced patient and when the bile duct stones are the non-opacifying type. In an occasional case of faint visualization of the gall bladder following the conventional 3 gram Telepaque test, the four-day Telepaque test has been helpful in identifying gall bladder calculi.

The phenomenon of gallstone opacification has been reproduced in vitro with the use of cholecystographic contrast media, Telepaque (Iopanoic Acid; Winthrop), Teridax (Iophenoxic Acid; Schering), Priodax (Iodoalphionic Acid; Schering), Iodeikon (Sodium Tetraiodophenolphthalein; Mallinckrodt), and Iso Iodeikon (Sodium Phenoltetraiodophthalein; Mallinckrodt), Cholografin (Sodium Iodipamide; Squibb), potassium iodide and the urinary contrast media are non-opacifying contrast media. About 20 per cent of 100 samples of unselected cases of biliary calculi found at surgery or autopsy subjected to the in vitro test proved to be opacifying gallstones. Grossly, the opacifying gallstones were always heavily pigmented although not all pigmented stones were opacifying. Gallstones were fractionated into cholesterol, inorganic salts, bilirubin and bile pigments. The opacification reaction occurred only with the bile pigments. Commercial cholesterol, bilirubin, and biliverdin were subjected to the in vitro test for opacifying quality. Only the biliverdin proved to be opacifying. Non-opacifying cholesterol stones were induced to opacify by coating these stones with biliverdin. These experiments have led us to conclude that the opacification of gallstones is due to a reaction between biliverdin on the surfaces of the stones and the contrast medium in the bile.

To explain the high incidence of opacifying stones among bile duct stones as contrasted with the low incidence of opacifying stones among gall bladder calculi, we have postulated that bilirubin which is normally the chief pigment of human bile is oxidized to biliverdin in the presence of duct obstruction, commonly accompanying bile duct calculi. The biliverdin is probably deposited on the surfaces of the bile duct calculi, creating opacifying bile duct stones. Our knowledge of the gallstone opacification reaction is, however, still meager. Work is in progress which we anticipate will divulge in greater detail the nature of the opacification reaction.

Summary

1. The four-day Telepaque test, a prolonged preparation for cholecystography to identify opacifying gallstones, is described.

2. The four-day Telepaque test is a useful method for identifying bile duct stones, the vast majority of which are opacifying, and is, probably, the best available method for identifying bile duct stones in the presence of jaundice.

3. Occasionally, the test is helpful in identifying gall bladder stones. •

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See the outstanding programs scheduled for September —

Rocky Mountain Medical Conference, pages 71-78

Utah State Medical Association, pages 82-87

Montana Medical Association, pages 94 and 98

Hidden rewards of skin biopsy

Barton L. Lewis, M.D., Colorado Springs, Colorado

The eyes of the microscope can often make a diagnosis when the unaided eyes of the physician remain puzzled. "Mail-order" consultation speeds diagnosis and therefore aids definitive treatment.

WHEN THE AVERAGE PHYSICIAN is confronted with a puzzling skin eruption or tumor, his first reflex maneuver is usually to order a complete blood count and urinalysis. It is hoped by this manipulation to discover some basic pathologic defect in the patient and thus explain the cutaneous change. Although frequently some aberration is discovered in these basic laboratory studies, it is not altogether logical to assume that because the patient has, for example, a depressed hemoglobin, that the cutaneous picture is a direct reflection of this underlying abnormality.

A more direct approach and probably the only specific approach to the diagnosis of the skin eruption is a microscopic examination of a piece of involved skin. This is well recognized in the case of tumors of the skin but is neglected all too often in inflammatory skin problems. The expense of skin biopsy with interpretation varies little from that of the basic laboratory tests mentioned above.

The biopsy is an extremely rapid office procedure which may not only lead to the diagnosis, or at least classification, of the confronting disease, but which can further the education of the physician. He can sit down with the microscopic slide and, by correlating what he sees under the microscope with what he sees on the skin, further his dermatologic education and improve therapeutic accomplishments.

Method of biopsy

The skin specimen is obtained easily either with a scalpel, scissors, or, best of all for a good specimen, a Keyes cutaneous punch (available from surgical supply houses in sizes 2 mm. through 8 mm., 4 mm. being the most commonly used size). Local anesthesia, preferably procaine with or without adrenalin, is desirable. An attempt is made to ring the area to be biopsed rather than infiltrating it and thus distorting some of the features. The piece of tissue loosened by the punch, scalpel or scissors is lifted with forceps to see that all three layers of the skin will be available for microscopic study. The lower layer, the fatty subcutaneous layer, appears yellow and is an easy landmark to establish. This layer is cut through with a small pointed scissors and the specimen placed in a small vial filled with 10 per cent formalin, which is obtainable in most pharmacies. If there is a question of bacterial or fungal origin, the specimen may be split longitudinally; one portion is dropped in formalin and the other in a sterile vial with a drop of saline to keep it moist. The latter specimen will then be available for special bacteriologic studies.

Hemostasis is obtained by pressure, a Gelfoam plug, electro-coagulation, or suture. The latter tends to minimize scar tissue formation. A 2 mm. punch wound will heal with little or no scar. This small size provides less microscopic information, but is sometimes of advantage on the face for cosmetic reasons.

The tissue obtained should then be sent to a dermatopathologist (dermatologist particularly interested in histopathology of the skin) or to a general pathologist who has

shown a particular interest in dermal pathology. Information should be enclosed as to the age of the patient, nature of the skin problem, and site of biopsy.

Such a biopsy if accompanied by a clinical photograph in color of the patient often is as valuable as referring the patient and is much simpler if the patient lives many miles from a point where dermatologic consultation is available. Examination of the specimen may lead by return letter to diagnosis and recommendations as to therapy. This can be of particular value if a therapeutic summary had been sent with the specimen.

Mail-order consultation

One of the major rewards comes with return of a microscopic slide of tissue to the physician submitting the specimen. The return of a slide is usually a routine part of a "mail-order" dermatopathologic examination. One of the most valuable tools a physician can have in evaluating skin problems both from a diagnostic and therapeutic point of view is the knowledge concerning which of the three major layers of the skin—that is the epidermis, dermis or subcutaneous layer —is affected by the particular skin disease present in his patient. This is not only of value in understanding the pathogenesis and physiopathology of the particular disease but is of real value from a therapeutic point of view. Those diseases affecting the epidermis as, for example, seborrheic dermatitis, are amenable to treatment from the outside with local preparations. Those diseases affecting the dermis, e.g., erythema multiforme, and subcutaneous tissue, e.g., Weber-Christian's disease, are incapable of responding to external treatment and must be treated by internal medication.

It is even possible for the trained dermatopathologist to recommend therapeutic agents; for example, in the case where he sees acanthosis (an inflammatory thickening of the epidermis) to recommend the use of ichthyol preparations, which reduce acanthosis, or by seeing liquefaction degeneration of the basal layer of the epidermis, to recommend as an example chloroquine, which is of value in most of the diseases showing this pathologic change. Among these diseases are lupus erythematosus and lichen planus.

Useful in systemic disease

In addition to inflammatory skin diseases that may be recognized under the microscope, many systemic diseases may be discovered even though they present what may seem to be rather non-specific changes on the skin. Approximately 20 per cent of lymphoblastomas present their first manifestations in the skin. Biopsy of the skin may show the early lymphoblastomatous change and even allow a breakdown as to the type of lymphoblastoma present.

Next, the patient who presents himself with a problem of hyper-pigmentation. Forewarned that this is the problem by a short clinical summary accompanying the biopsy specimen, it is a simple matter to differentiate the melanin of Addison's disease from the iron of hemochromatosis and the silver of argyria. A patient whose chief problem is warm or tender red nodules over the skin may disclose under skin biopsy periarteritis nodosa, sarcoidosis, lymphoblastoma, deep fungus infection, a drug eruption (for example, from iodides), or metastatic carcinoma.

It is possible on skin biopsy to differentiate the generalized edema, for example, of renal disease from the edema of hypothyroidism. Scarring erythematous plaques seen especially on the face should be biopsied to differentiate lupus erythematosus from tuberculosis and carcinoma. Biopsy of a verrucous thickened patch over the lower anterior tibial regions may reveal amyloid disease, lymphedema, or the peculiar localized myxedema which may follow surgical or chemical thyroidectomy.

Roughened pigmented lesions in the axillae cannot always be passed over lightly. Skin biopsy may reveal a peculiar change known as acanthosis nigricans, which in the post-pubertal non-obese individual is almost pathognomonic of glandular carcinoma elsewhere in the body, particularly the gastrointestinal tract.

A dilemma which is not always solved by an objective diagnosis is that of determining the direction in which the intersexual individual should be led surgically and emotionally. It is now possible to determine from the microscopic study of skin cells whether the individual is somatically male or female.

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If there is yellowing to any of the lesions on the body, for example, in the xanthomas or in the skin plaque of diabetes (necrobiosis lipoidica diabeticorum), a note regarding the suspicion of fat should be sent along to the dermatopathologist. He can then make special arrangements for a frozen section because normal processing of the tissue will wash out the fat.

It is possible that early in an epidemic of a generalized vesicular disease it would be hard to tell a hemorrhagic chicken-pox from smallpox. Some help may be obtained by a biopsy of an early vesicle, which may differentiate the two diseases on the basis of the location of the inclusion bodies in the cells.

Tender erythematous nodules on the legs on biopsy may reveal erythema nodosum, sarcoidosis, nodular vasculitis, erythema induratum, Weber-Christian's disease or periarteritis nodosa. Many of the deep fungi, by producing a somewhat dissimilar architectural pattern in the skin, may be differentiated. There are now available special stains for fungi which can even further aid in the differential diagnosis of both deep and superficial fungi.

Many of the above mentioned specific diseases are systemic in origin; these are greatly outnumbered by the great many microscopically distinguishable non-systemic skin disorders.

Summary

Even in the case where a specific diagnosis cannot be made by microscopic examination of a specimen removed from a pathologic skin, it must be repeated that the biopsy slide returned to the physician is of the greatest value in determining the parts of the skin involved by the process; this, coupled with clinical interpretation, gives some direction in planning a worthwhile therapeutic program. •

Hypnoanalgesia in medicine*

Curtis Pearcy, M.D., Denver

Application and limitations of a useful procedure will be less mysterious after you read this article.

THIS PAPER WILL DEAL with the application of hypnosis to relief of pain. I wish to distinguish this use of hypnosis from the uses psychiatrists find for it. Psychiatrists use hypnosis as an aid in diagnosis and treatment of mental disorders. Anesthesiologists use the same tool to accomplish relief of pain and relief of anxiety that accompanies pain. Because the psychiatric implications of hypnosis are great, the anesthesiologist must be forever wary of overstepping the bounds of his knowledge and experience, and avoid psychiatric problems and psychiatric treatment. In most circumstances this presents no problem, and the application of hypnosis to problems of pain is enough to be an area of treatment in its own right.

Hypnotism dates back to the time of Mesmer, who about 1800 first described animal magnetism. Mesmer and his followers were the first to investigate the properties of suggestion. When the Freudian school abandoned hypnotism in favor of other psychiatric methods, hypnotism was largely perpetuated by entertainers, magicians, and showmen. The medical profession largely looked upon a hypnotist as a quack or a charlatan. During the past decade there has been a resurgence of medical interest in hypnosis, and reputable

*Presented before the Section on Anesthesiology, Colorado State Medical Society, September 26, 1958. From the Division of Anesthesiology, University of Colorado Medical Center, Denver.

uses for hypnosis are being found. The British Medical Association adopted a resolution in 1955 to the effect that hypnosis is of value in medicine[1]. The Council on Mental Health of the American Medical Association, reported in the A.M.A. Journal, admits the medical value of hypnosis[2]. An excellent discussion of the history of hypnotism can be found in Dorcus' book[3], or the recently reprinted work of Moll[4].

The mechanism of hypnosis is best summed up by admitting that it is not understood. There are many theories, but none has been substantiated. It is my guess that we shall remain ignorant of the hypnotic mechanism until we understand more of the basic mechanism of the human brain. Until we understand how we think, we shall not understand how we alter a thought. Until we understand what pain is, we cannot understand how, by force of will, a person can cease to feel the pain. Until we understand memory, we are at a loss to explain amnesia. Until we understand the human mind, I doubt that we shall understand hypnosis.

An adjunct to anesthesia

While we cannot explain hypnosis, we can describe some features of it. The subject under hypnosis has his thoughts controlled by the suggestions of the hypnotist. The hypnotist suggests, and the subject follows the suggestion. Therefore hypnosis has been termed "controlled suggestion." The hypnotist suggests that the subject cannot open his eyes, and the subject cannot. The hypnotist suggests that an extremity is numb and has no feeling, and the extremity becomes anesthetic. The hypnotist suggests amnesia, and the subject has no memory for the events. Why the suggestions are taken is unknown; that they are taken is incontrovertible. I again refer the interested to Dorcus for a discussion of the present theories of hypnosis.

The lay press has made much ado about the rather spectacular features of hypnosis in anesthesia. Recently an article in a leading weekly news magazine described the use of hypnosis as anesthesia for major cardiac surgery. Hypnosis as the total anesthetic for cesarean section has been described. Amputation under hypnosis is a classical picture of hypoanesthesia to the layman. Such sensationalism is likely to cause the medical profession to lose sight of the basic and simple values of hypnosis. For hypnosis has much value for the anesthetist in the routine management of patients, and in my opinion little value as a total anesthetic. Let us then examine some of these less spectacular applications.

A major purpose of preanesthetic medication is to achieve psychic sedation of the surgical patient. Light hypnosis accomplishes this psychic sedation gracefully and adequately without concomitant respiratory and circulatory depression. The patient who demands to be completely unconscious, to know nothing of the operating room or any part of the surgical preparation, can be helped tremendously by a hypnotic trance before surgery. Frequently a session of hypnosis the evening before surgery is all that is required. Perhaps that patient will need hypnotic sedation in the room before coming to the operating suite. This is illustrated by the case of a 50-year-old lady scheduled for radical mastectomy who was almost hysterical the evening before surgery. She was hypnotized, the surgical preparation explained, and she was given a post-hypnotic suggestion that she would have no anxiety. Next morning in the operating suite she was again hypnotized, and anesthesia was induced without incident. She was given only light drug sedation. This patient's psychic need was met without the risk of heavy doses of depressant drugs.

The tranquility produced by hypnosis is of decided value in promoting a smooth induction of general anesthesia. Even with an ether induction, a pronounced excitement phase is unusual in the hypnotized patient. The feeling that all is well seems to remain with the patient even when he is losing his voluntary control.

Hypnosis as an adjunct to regional anesthesia can make a perfect block out of a block that by rights should be only partially successful. A patient was given a spinal anesthetic for an intramedullary nailing of the femur. The level of anesthesia began wearing out before the upper end of the incision was closed. Hypnosis enabled the procedure to be completed without additional general anesthetic. Often a regional block is considered the safest form of anesthesia for a particular

patient, but the patient is apprehensive about being awake during the procedure. His apprehension is often completely relieved by light hypnosis. On occasion the pulling and pressure that patients feel through the best regional block is quite disturbing. Hypnosis can often be the answer to this problem.

In other ways hypnosis can facilitate regional anesthesia. A young girl required surgery to her legs after an automobile accident. Her jaws were wired together because of extensive fractures of the mandible, and she was frightened at the thought of a needle stick. With her wired jaws, general anesthesia presented a serious hazard. Under hypnosis a spinal tap was done without difficulty, and the surgery proceded under adequate spinal block. Later this same patient had her jaw wires removed under hypnosis. Obviously hypnosis is not the only supplement to regional anesthesia. Certainly a small amount of barbiturate, opiate, or tranquilizer can improve regional anesthesia tremendously. At the same time, it is my feeling that often a patient is drugged when hypnosis could accomplish the same end with probably less metabolic upset to the patient. Sometimes, as in the case of the girl with the wired jaws, hypnosis is far and away the safest supplementary agent.

In a selected few patients, hypnosis can be used as the total anesthetic for major surgery. Estimates of the number of people who can achieve complete anesthesia with hypnosis alone run from 10 to 20 per cent of the general population. I am aware of no method of predicting which person is capable of hypnotic anesthesia. Some people can be made anesthetic in as little as five minutes of the first session of hypnosis. Others cannot achieve anesthesia even after numerous sincere trials. With a very suitable patient, a laparotomy can be performed with no sedative other than hypnosis. The percentage of patients on whom this can be done is very small, however. In reading the sensationalist literature one needs constantly to be aware of the small percentage of patients in whom such remarkable results can be obtained.

A far larger group of patients can reach varying degrees of anesthesia and amnesia under the influence of hypnosis. Perhaps three-quarters of patients can reach a level of hypnosis adequate for some degree of analgesia. In this group are found the patients who stand to gain the most from the judicious use of hypnosis, for in them minor procedures can be performed without discomfort. Usually previous trials of hypnosis are not necessary. The procedure and its implication is explained, hypnosis is induced, a sound level is established, and the procedure performed quickly. Among the procedures which can be done under hypnosis are incision of an abscess, pulling of teeth, removal of splinter or similar small foreign body, removal of sutures, dressing changes, lumbar puncture, and pelvic examination. These have in common some degree of discomfort, short duration, and less than maximal pain stimulus. The more severe the pain, the shorter the duration that a hypnotic trance can be made effective. A superficial abscess can be incised with a quick stroke of the scalpel, and hypnosis will give adequate analgesia. Drainage of a deeper abscess requiring probing of pockets might not be successful under hypnosis. Do not be ashamed to supplement the hypnosis with a small intravenous injection of opiate if hypnosis does not seem to be deep enough. Do not falter with the painful procedure for the patient will be quick to sense indecisiveness, and will be unnerved. The physician must fairly exude confidence and impress the patient with sincerity, skill, and conviction.

Alleviates postoperative discomfort

Hypnosis for obstetrical anesthesia has some place, and depends for much of its success on the rapport that the physician has with the patient. It requires time, patience, and preliminary trances for success. Perhaps "natural childbirth" is a form of hypnosis. In selected patients hypnosis has a place in obstetrical anesthesia. Mass application would, I fear, meet with many failures and be quite burdensome to the obstetrician.

Postoperative pain frequently can be relieved by posthypnotic suggestion. During the preoperative trance, the patient is told that he will be able to withstand his postoperative discomfort. He is told that he will ambulate and cough, as is necessary. He is told that he will have minimal postoperative nausea. Any special postoperative instruc-

tions are given similarly as a posthypnotic suggestion. Often this one period of hypnosis will alleviate much of the usual postoperative discomfort. In some patients a postoperative trance may prove advantageous to reinforce the suggestions. One is impressed with the few narcotic injections required by posthypnotic patients.

I wish to emphasize again the less spectacular applications of hypoanalgesia. As a supplementary analgesic, hypnosis can be a big helper. As total anesthesia, hypnosis has limited use. Use it to accomplish minor procedures which are really more frightening than painful. Use it selectively in obstetrics. In these your failures will be few, your successes many, and your patients grateful. •

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Clinical experiences with enuresis

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Bed-wetting may be due to organic disease, poor toilet training, or emotional disorders. Proper treatment, therefore, depends on accurate diagnosis.

SOME PHYSICIANS DO NOT SEEM TO TAKE the problem of enuresis seriously. There are even some urologists who refuse to concern themselves with enuresis and there are not many G.P.s or pediatricians whose eyes light up with instant interest upon hearing that little Esmerelda wets the bed. This lack of enthusiasm is perfectly understandable and is due both to the fact that a simple, precise, organic diagnosis is not easily made, and that the response to variously recommended treatments is notoriously unpredictable. No doctor likes to handle a case when he doesn't know exactly what he is treating, doesn't know how to find out, and doesn't know what to treat it with anyhow.

Here is a brief outline of the manner in which we handle these children at the Boulder Medical Center. If not a precise diagnosis, we believe that at least a working diagnosis can be made and that the response to treatment will improve considerably if such treatment is individualized to each patient's needs. We have found this approach reasonably satisfying although by no means entirely free of frustration and failure. We do believe that the problem justifies our efforts and our small degree of success has stimulated a more optimistic, aggressive attitude toward enuresis within our group.

The don'ts

Before stating what we do do, let me make clear what we do not do. These "don'ts" embrace the extreme approaches to enuresis. First, we don't tell the parents their child will "outgrow the habit." This answer might let you slide by little Esmerelda if she is only 4 years old but it is difficult to apply successfully if she happens to be a well-rounded 15. In almost every case the physician can be of some help to the parents in their quandary and should attempt to do so.

Neither do we do a complete G.U. work-up on every enuretic we see. This might be the rigidly scientific thing to do but we do not believe it practical or necessary. To justify a complete work-up, there should be a reasonable possibility of turning up some pathology, because of the expense entailed.

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A certain selectivity in picking those cases calling for urologic study will obviate considerable unnecessary expense and instrumentation. The risk that the alert physician would miss important pathology is small indeed.

It has always seemed illogical to apply a blanket treatment such as belladonna, Dexedrine, or Banthine to all cases of enuresis, and yet a review of the literature will show each author urging his particular treatment for all such cases. Surely there is more than one cause of this disorder and no single spasmodic or antispasmodic will correct more than a small per cent of the total. Results should be better if our efforts could be more accurately directed at the particular etiology of each case. To this end we broadly classify the causes of enuresis as seen in Table 1.

In our initial interview we decide into which of these three groups the child most likely falls. This gives us a starting place. Admittedly, this classification is only an educated guess but it is tentative and can be changed at a later date if the child fails to respond to the outlined treatment or if further pertinent facts come to light.

Table 2 shows the facts and findings we usually elicit in arriving at our initial classification. After going through this list of questions and doing an examination, we generally have a strong impression as to underlying etiology and therefore the most likely and fertile place to begin therapy. The characteristic findings for each etiology will be pretty obvious but let us briefly review them:

1. If the enuresis is sporadic — ceasing with changes in environment, especially removal from the parents, I suspect an emotional cause.

2. If all the children in the family are enuretic, I suspect an emotional cause unless some extreme training mistake was made in each case.

3. If either parent was enuretic and the child is aware of this fact, to me that implies an unhealthy permissive attitude within the family.

4. Details of toilet training methods employed might reveal obvious defects or omissions, indicating that the child never really had a chance to develop a normal control.

5. *Any* significant associated symptom implies organic pathology until proved otherwise.

6. Same with infection.

7. Severe constipation or fecal incontinence suggests neurogenic pathology.

8. A healthy adjustment to school, friends and within the family weighs against a pure emotional cause.

9. Some leads as to the etiology may be obtained from results of previous treatment.

10. Significant findings on examination might indicate an organic basis for the enuresis. Don't overlook meatal stenosis, and check anal sphincter tone.

11. The finding of pyuria has the same significance as a history of infections and requires study.

Now, if the child is classified in the group suspected of having organic pathology,

TABLE 1

Classification of etiology

1. Organic genitourinary pathology—usually congenital.
2. Inadequate or incomplete toilet training.
3. Emotional disorders, mental retardation, etc.

TABLE 2

Pertinent facts and findings

1. Has the enuresis been life-long or sporadic?
2. Are the siblings also enuretic?
3. Were the parents enuretic and does the child know this fact?
4. Details of early toilet training.
5. Are there any associated urinary symptoms; viz., frequency, urgency, diurnal incontinence, burning, straining to void, etc.?
6. Is there a history of urinary tract infections?
7. Is bowel function and control normal?
8. Is general mental and emotional development normal?
9. Details of previous treatment and response to such treatment.
10. Complete physical examination.
11. Urinalysis.

we tell the parents of our suspicions and add that although nothing may be found, the only way to be sure something is not wrong is to do a complete hospital urologic examination. This consists of an excretory urogram followed by cystoscopy, retrograde cystogram and measurement of residual urine. Other studies may be done as indicated. I shall not elaborate on all the possible congenital abnormalities which can produce enuresis and all the appropriate measures designed to correct them. Suffice it to say that occasionally one finds serious obstructive or neurogenic pathology; more frequently, minor abnormalities such as granular urethritis, trigonitis, slight degrees of bladder neck contracture, and hypertonic bladder are found. Many times nothing abnormal is uncovered.

Tailoring the treatment

Our biggest problem is deciding whether minor changes, especially those found cystoscopically, are clinically significant and related to the patient's symptoms. At any rate, we attempt to tailor the treatment to the abnormality found. This might be periodic dilatations of a mild bladder neck contracture; it might be silver nitrate instillations for a granular urethritis, spasmolytic drugs for hypertonic bladder, or meatotomy for meatal stenosis, and so forth. Treatment of the major defects is well established and need not be further discussed here. In reviewing our records while preparing this paper, it was noted that in the past year in examining children referred for enuresis only, we uncovered two cases of neurogenic bladder from myelodyspasia, one case of severe bladder neck contracture with early bilateral hydroureter and one case that fulfilled all the criteria of interstitial cystitis although we previously had never seen a case in a young child.

If no abnormalities are found, we renew our thinking about possible faulty training, or emotional causes. If considered possibly significant, they are tracked down but if not, the child is treated arbitrarily with gentle dilatation of the urethra and vesical neck with or without the instillation of silver nitrate into the posterior urethra and bladder. The response to this purely empirical treatment is often gratifying and worth an attempt, although I am not prepared to say whether the response is due to the treatment's organic or psychic effect. I wish to stress that this is done only in those cases where all other leads appear to have been exhausted.

Training methods

In that large group of cases in which training methods have been faulty, we attempt to retrain them. Consistency is the key word. Sometimes the parents are employing proper methods but are impatient with a child who just hasn't had time to respond to basically correct training. Such parents merely need reassurance and encouragement. In retraining the child, the cooperation of the parents is needed and the physician must secure it. A firm but friendly parental attitude is sought. The child must be given the impression that the parents and doctor are combining on a program of training that is immutable. It will continue despite their objections and evasions until the desired results are obtained. The objective sought is that the child awaken when the bladder is full and therefore fluids are not restricted. Most parents are already aware, or can easily observe, about what time of the night the child is incontinent and this time is fairly consistent. About one-half hour before the expected incontinence the child is awakened completely in his bed, made to get up, walk to the bathroom and void. For older children an alarm clock may be set across the room to awaken them. Now, I know the difficulties of convincing the parents of the importance of each detail of this activity, but they are vital to success. The child must be awakened completely, every single night, preferably by mother and father taking turns. Parents are encouraged to be patient but firm in awakening the reluctant children. The child should not feel that this plan is harder on the parents than it is on him—even though it undoubtedly is. Discipline is discouraged but any possible means of reward for prolonged continence such as the time-honored gold stars is permissible. The child will show that he is beginning to respond to the training methods when he awakens before the parents can get there. One can then try letting him go without awakening for a trial.

Now a word about the "Enurtone." It is

merely a substitute for the above outlined training program and is acceptable as such. It has no magic qualities. However, if parents desire to get one or they indicate that they are weakening in getting the child up each night, I recommend its use. By either means —parental or electrical awakening—you must not stop too soon! It takes some time to firmly establish a conditioned reflex. The frequent relapses following the use of these gadgets result from too short an exposure. The cost may have something to do with this. If a child in this "training" group does not respond at all to prolonged proper training methods, a urologic investigation is carried out. If no abnormalities are found, he is treated empirically as previously outlined.

In the final group with obvious severe emotional problems the child is referred to the family physician, pediatrician or to a child guidance clinic for follow-up. As one finds out what is bothering the child, and as something is being done to improve the health of the intrafamily relationships, the enuresis takes care of itself. A doctor close to the family is best able to be of help in these cases. It has been our experience that except in obviously disturbed or exceedingly dependent or retarded children, pure emotional causation of this condition is not too common.

Summary

We have considered a program to help enuretic children by first attempting to find the most likely cause of the condition. We then proceed in a step-wise fashion with urologic investigation and treatment, retraining methods, psychologic consultation or empiric treatment as circumstances indicate. •

Conservation of ovarian tissues in pelvic surgery*

Horace E. Thompson, M.D., Denver

There are five good reasons why ovaries should be preserved whenever possible in pelvic surgery. Removing them routinely will prevent cancer in only one case in a thousand.

THE AGE OLD QUESTION of the prophylatic removal of normal ovarian tissue when other pelvic surgery is being done on patients who have no further desire for child bearing has been a thorn in the side of surgeons since the advent of modern surgery. As early as 1876 Battey[1] recommended the prophylatic removal of both ovaries in the treatment and prevention of many maladies that befall women. In view of the high mortality rate of ovarian carcinoma it is felt by many surgeons that needless loss of life can be prevented by this procedure. Fagan[2] feels that all patients past the age of 40 should have routine bilateral oophorectomy when other surgery is done. Grogan[3] even goes so far as to say that the ovaries should be removed at hysterectomy at any age in life. However, in the light of more recent investigation of this problem, many men, including the author, feel that this is a short-sighted viewpoint.

More than reproduction

Too little consideration has been given to the dual role played by the ovaries in the

*Read before the Annual Session of the Colorado State Medical Society, September 25, 1958.

well being and normal function of the body of the female. For years, and even today, too many surgeons think only of the reproductive role of the ovaries and give no thought to the endocrine value of these organs, namely, their balancing effect upon the whole chain of endocrine glands, their inhibitory control over the pituitary and its secretions, the fact that they are found to function as an endocrine gland, in many instances, long after the menopause, and their role in the control of certain metabolic disorders such as osteoporosis, arteriosclerosis, etc.

Recently in discussing his paper on "Ovarian Function After the Menopause," Dr. Clyde Randall[4] made this rather amusing but profound statement: "When we consider the number of ovaries that have been removed in our efforts to protect women from the risk of ovarian cancer, as more and more women take up the knife in our hospitals, it seems inevitable that they will soon be convinced that they should castrate us males to save us from arteriosclerosis. Then we will know, no doubt—though we may not actually live longer—that to the castrate, life at least seems longer!!"

Most of us will agree that in young women below the age of 40, ovarian tissue should be preserved, if possible, when doing pelvic surgery for benign conditions. But all too often in the patient past 40 the thought is, "They are no longer of any value, so take them out." Prevention of carcinoma of the ovary is the principal thought in the surgeon's mind, but prevention of benign lesions is also considered, thus saving the patient from future pelvic surgery. The question of whether the ovaries function after the uterus has been removed, and if so for how long, is also considered.

Certainly carcinoma of the ovary is a dreaded disease. According to Randall[5], the five-year survival rate varies from 11 per cent to 15 per cent. This is without question a poor prognosis. Early detection of cancer of the ovary is difficult, and anything that might improve this situation must be given careful consideration. To date, according to a recent report by Hillebol[6], from the New York State Health Department, the rate of deaths due to carcinoma of the ovary has actually increased over the past ten years rather than decreased, so apparently no improvement has resulted from the prophylactic removal of ovaries. Before we decide to remove ovaries indiscriminately to prevent ovarian cancer we must first know something about the incidence of cancer of the ovary.

Incidence of cancer

This incidence is generally reported, according to Randall[4], as a little less than 1 per cent. At no time in life are the "odds" any greater than nine chances in 1,000, and after the age of 50 the probability of death from ovarian cancer drops rapidly. This statement may not seem valid on the surface, in view of the fact that 70 per cent of cancer of the ovary is found in women after the fifth decade of life, but it is more apparent when we consider that most women at the age of 50 will die in a relatively few years from some other disease. If we take an arbitrary figure and say that one out of every ten women will have pelvic surgery for a benign condition after the age of 40, and in all of these patients we removed both ovaries, we would prevent less than one woman out of every 100 that we operated from developing cancer of the ovary and in the over-all female population less than one in 1,000 from cancer of the ovary. Even with these small figures this would be a justifiable procedure if this were the only consideration, but many other factors must be considered before we go to this extreme.

As to the function of ovarian tissue after hysterectomy in patients under the age of 40 when the ovaries are not removed, Randall[5] has shown by vaginal smear that from two to five years after surgery only 10.2 per cent will show marked to moderate estrogen deficiency. In a group of all ages in which the ovaries were removed, 39.2 per cent showed ovarian failure two to five years after surgery. Likewise a study done by Bancroft-Livingston[7] showed that women having hysterectomy done before the age of 45 and the ovaries preserved, only 5 per cent had atrophic smears three years following surgery. In a group operated on over the age of 45, 25 per cent showed inactive smears after three years. He concludes that hysterectomy with conservation of ovarian tissue does nothing to hasten the onset of ovarian failure.

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Function after menopause

With regard to ovarian function after the menopause, Randall[5] in a study of 812 women shows that the ovaries do not suddenly cease functioning when menstruation stops. Only 17.7 per cent show marked to moderate estrogen deficiency one to two years after the menopause, 30.1 per cent at two to five years, 36.9 per cent at five to ten years, 53.5 per cent at ten to 15 years and even at 15 years plus only 50.7 per cent show marked to moderate estrogen deficiency.

More striking evidence of ovarian function and importance to health and well-being is presented in a highly publicized paper by Griffith[8] in "Obstetrics and Gynecology," May, 1956, in which he shows decade by decade that in oophorectomized women the incidence of severe coronary arteriosclerosis was 10 per cent to 45 per cent greater than in those in which the ovaries were intact.

Griffith[8] also emphasizes the importance of ovarian tissue in maintaining normal interrelations with other endocrine glands, namely, in the adrenals, cortical hypertrophy and blood pressure increases in the patient with previous hypertension, in the pituitary, increased secretion of anterior pituitary growth hormone and in the thyroid, decreased function.

Lost endocrine balance

Masters[9] also emphasizes the importance of ovarian function in endocrine balance, such as decreased thyroid function and increased gonodatropin production when ovarian tissue is eliminated. He states, "With clinical failure of the gonad, the fine balance of mutually stimulative secretory function, or interglandular dependence, is lost to the entire endocrine chain."

Ibarra[10] stresses the function of estrogen in preventing osteoporosis. This is due to a negative protein balance as a result of the deficiency of the protein anabolic estrogen hormone; consequently, there is a decreased deposition of calcium in the bony tissue.

McCall, Keaty, and Thompson[11] have recently reported a series of 26 cases of carcinoma of the cervix in which radical abdominal hysterectomy with pelvic lymphnodectomy was done but the ovaries were not removed. They report that there were no cases of ovarian metastasis postoperatively, the well-being of the patients was much improved and there was evidence of good ovarian function by laboratory methods as compared with a group of controls. This emphasizes the fact that even in the face of certain types of cancer it may not be necessary to remove ovarian tissue when pelvic surgery is done.

Siddall and Levine[12] feel that unilateral oophorectomy should be done in women under the age of 35 when other pelvic surgery is indicated, thereby reducing the incidence of cancer of the ovary by 50 per cent. This may be justifiable, but Griffith[8] points out that too little ovarian mass may bring on ovarian failure.

Summary

Now in summary let us quickly review the reasons for conserving normal ovarian tissue:

1. The prophylactic removal of ovarian tissue will reduce the over-all incidence of carcinoma of the ovary by less than one in 1,000.

2. The general opinion of most workers is that the over-all well-being and mental attitude of the patient is preserved by conserving ovarian tissue.

3. The interglandular dependence is lost to the whole endocrine chain when the ovaries are removed.

4. In patients with previous hypertension the blood pressure is frequently increased when the ovaries are sacrificed.

5. Removal of the ovaries results in a 10 per cent to 45 per cent increase in severe coronary arteriosclerosis, regardless of the age of the patient.

6. Osteoporosis is more commonly seen and develops earlier in oophorectomized patients.

7. It has been proved without question that the ovaries do continue to function after hysterectomy.

8. There is unquestionable proof that the ovaries do continue to function as an endocrine gland after the menopause for varied lengths of time, thereby giving protection to the body from severe degenerative conditions.

9. The body requirements of the ovarian hormones is not known and it is difficult to know what quantities and what hormones to give to oophorectomized patients to replace this need.

Conclusion

From the evidence at hand as reported by various investigators on the subject, I feel that it behooves us as surgeons to rearrange our thinking and be far more conservative in the removal of normal ovarian tissue regardless of the age of the patient. Until further evidence is available to the contrary, we must consider the ovary as a functioning, important endocrine gland and protect our patients by leaving normal ovaries intact at any age in life when pelvic surgery is indicated for benign conditions. •

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Leukemia and pregnancy*

John S. Flint, M.D., Denver

An illustrative case is summarized, recent literature discussed with respect to survival and management of the pregnant leukemic, and some speculative observations made on the nature of the placental barrier.

BECAUSE OF INCREASING INCIDENCE OF LEUKEMIA and advances in methods of treatment, the coincidence of leukemia and pregnancy is of growing interest to both obstetrician and internist. The many case reports in recent literature is evidence of this interest. Because of lack of uniformity of clinical data and their interpretation and the variable nature of the leukemic process itself, valid conclusions drawn from a case or series of cases are difficult to formulate and are subject to misinterpretation, as evidenced by variable and often conflicting opinions rendered by various authors on this subject.

CASE REPORT

C.G., a 31-year-old white gravida ii, para i, was seen during the seventh month of pregnancy because routine blood counts showed persistent leucocytosis of 90,000 to 100,000. The patient was asymptomatic, and her pregnancy uneventful. Past and family histories were non-contributory. On examination the uterus was enlarged to the size of a seven-month pregnancy, but there were no other significant physical findings. The liver and spleen were not palpable, there were no enlarged lymph nodes and no hemorrhagic manifestations. Her hemogram showed hemoglobin 10.4 grams or 67 per cent; erythrocytes, 3,680,000; leucocytes, 90,000; differential in per cent—neutrophiles, 65; eosinophiles, 1; basophiles, 1; metamyelocytes, 16; myelocytes, 14; lymphocytes, 3; platelets were 254,000/cu. mm. Chest x-ray was normal. Bone marrow showed granulocytic hyperplasia with some shift toward immaturity of cells. Diagnosis of chronic myeloid leukemia was made on the basis of blood and bone marrow findings. Throughout the rest of her pregnancy the patient was given no treatment other than iron and vitamins. On November 17, 1949, her WBC was 76,000, and hemoglobin 76 per cent. Uncomplicated delivery of a normal male infant was accomplished on December 2, 1949. On February 8, 1950, the WBC had risen to 97,500 with 36 per cent immature forms, platelets were 354,000, and the spleen was enlarged to three centimeters below the costal margin. Five millicuries of P-32 were administered that day. The WBC fell to 39,000 in May, but rose again to 110,000 on August 16, 1950, when she was given another five millicuries of P-32 intravenously. She became pregnant again in October, 1950. Because her physicians feared an exacerbation of her disease during pregnancy, therapeutic abortion was advised, and was carried out on December 4, 1950. Her WBC was 11,250, hemoglobin 68 per cent. Three weeks later her WBC was 7,800,

*Presented before the Annual Meeting of the Colorado State Medical Society at Colorado Springs, September 26, 1958.

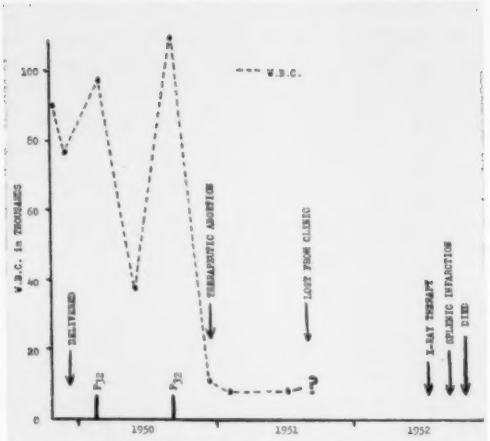

Fig. 1. Diagram of highlights of course of C. G., a patient with chronic myeloid leukemia complicated by pregnancy.

with normal differential. With no further treatment she remained in clinical and hematologic remission through June, 1951, when she disappeared until June, 1952. Exacerbation of leukemia then brought her to the Hospital of the University of Pennsylvania where she was given x-ray therapy to the spleen and long bones during July and August. She improved, but died after a splenic infarct on October 16, 1952. Her child was normal when last seen in 1951.

Comment

Two pregnancies occurred during the course of chronic granulocytic leukemia in this patient. Duration of disease from diagnosis to death was 36 months. It would be difficult to say whether the therapeutic abortion was wise, or if it had any effect on the course of this patient's leukemia.

Discussion

Leukemia is a rarely encountered disease, and the coincidence of pregnancy with leukemia even more rare. Some of the reasons for the rare occurrence of pregnancy in leukemia are: (1) the infrequency of pregnancy with debilitating disease, (2) the short duration of life in acute leukemia, (3) infertility due to infiltration of the reproductive organs by leukemic cells, (4) chronic leukemia, especially the lymphoid type, is usually seen in older individuals past the child-bearing age and (5) efforts made to avoid pregnancy when the diagnosis of leukemia is known.

Since Erf's summary of 100 cases in 1947[1], 60 additional case reports were collected by Sheehey[2] (including the seven cases from the Czechoslovakian literature in an addendum to this paper). Three other cases not listed in his report[3] plus the one presented here make the present total of reported cases 164. Of these, 137 are listed as granulocytic (40 acute and 97 chronic), 20 are lymphoid (16 acute and 4 chronic) and 7 are monocytic (all acute).

It is encouraging that, as expected, the survival time in acute leukemia complicated by pregnancy has increased in recent years. In a recent analysis by Yahia, Hyman and Phillips[3] of 32 cases of acute leukemia in pregnancy seen since 1948 who received steroid and/or antimetabolite therapy, the average total duration of disease from diagnosis to death was 5.9 months which contrasts favorably to that in a comparable review by McGoldrick and Lapp in 1943[4] in which it was only 2.5 months. Concurrently the fetal mortality has decreased from 60 to 38.7 per cent. In chronic leukemia the survival time is much more difficult to analyze, since the natural course of the disease is so variable, and many of the case histories are incomplete because the reports were made while the patient was still living. Tivey[5] found that 50 per cent of 2,000 patients with chronic leukemia were dead 2.65 years after the diagnosis was made. In 33 cases of chronic leukemia during pregnancy reviewed by Sheehey[2] whose duration of disease was known, the 50 per cent mortality point was reached in 2.5 years, which is a favorable comparison, considering that Tivey's group included males and older individuals. There are no comparable figures from previous studies to show whether this represents an increase in survival time in recent years. Surprisingly, the fetal mortality in chronic leukemia is virtually unchanged, being 16.4 per cent in McGoldrick and Lapp's 1943 study and 16.2 per cent in Sheehey's 1958 review.

The purpose of therapy when pregnancy coincides with leukemia is the maintenance of the pregnancy to as near term as possible, with vaginal delivery the method of choice. All but two authors on the subject since 1950[6, 7] agree that pregnancy does not signifi-

cantly alter the course or prognosis of the leukemia. Interruption of the pregnancy defeats our purpose in therapy without serving any good end. In acute leukemia, artificial termination of the pregnancy results in premature and non-viable infants, and the operative procedure is almost certain to shorten the life of the mother. For this reason acute leukemia is never an indication for abortion. In chronic leukemia, with careful obstetric and hematologic management a live baby will be obtained in nearly 85 per cent of cases, even though leukemia is a recognized cause of spontaneous prematurity. Unusual difficulty during delivery, such as excessive hemorrhage, is rare despite the hemorrhagic tendencies encountered in leukemia. Only three of 114 cases reviewed by Harris[8] had severe hemorrhage. Therefore, there is no disadvantage in carrying patients to as near term as possible and delivering them normally where obstetrically feasible. Aside from purely obstetrical reasons, cesarean section is indicated only when, after the fetus becomes viable, the mother fails rapidly despite therapy and her death seems imminent. In this instance, emergency section may save an otherwise doomed infant. Since fetal death nearly always precedes maternal death in these cases, postmortem section would be expected to be futile.

Individual consideration

In management of the leukemia in pregnant patients, conservative supportive measures directed to keeping the mother alive and in reasonably good condition should be fully utilized. These measures include iron, vitamins, antibiotics, transfusions and steroids as indicated. If the leukemia progresses and poses an immediate threat to the mother's life despite these measures, suppressive treatment for the leukemia must be considered, and the risks to the mother and infant weighed. Each case requires individual consideration in the light of its peculiar circumstances, and no general rules for therapy can be applied. The few reports of antileukemic treatment given during pregnancy are encouraging, and seem to indicate that, where necessary, suppressive treatment can be carried out without necessarily harming the fetus. In acute leukemia the steroids can be used as suppressive agents without causing unmanageable adrenal insufficiency in the infants at or after birth. They have been used in extremely high doses successfully (e.g., meticorten, one gram daily), but whether this massive dose produces better results than more ordinary doses is still open to question. Local x-ray to the thorax, long bones and spleen has been given during pregnancy with no apparent ill effects to the child[9]. Pelvic irradiation, or total body irradiation such as is obtained with P-32 is contraindicated, and one patient who was given P-32 in the eighth week of an undiagnosed pregnancy had a stillborn baby, possibly because of the effects of the P-32[7]. However, one patient with chronic granulocytic leukemia received myleran throughout her pregnancy[10], another was given urethane from the fourth month on[11], and both of these women had normal babies. Two cases of acute leukemia treated with 6-mercaptopurine have been reported. Of these, one received 6-MP for a period of six weeks beginning at the sixth month of pregnancy, and had a normal, full term infant[12]. In the other, treatment antedated the pregnancy by two months, and was continued at 2.5 mgm/Kg. throughout the pregnancy which resulted in a three-pound premature infant who lived only 48 hours, but had a normal blood picture[13]. Bierman has reported one case of acute lymphoid leukemia treated during pregnancy with triethylene melamine and x-ray[14]. The infant was leukopenic at birth, but promptly recovered and developed normally. I have found no reports of nitrogen mustard, triethylene phosphoramide, aminopterin or chlorambucil being used during pregnancy. From our knowledge of the various agents used in the suppressive treatment of leukemia, and the results obtained in the reports mentioned above, it would appear that local x-ray (avoiding the plevis), myleran, urethane, and even T.E.M. can be used in treatment of chronic leukemia during pregnancy when the need for treatment justifies the potential risk of such therapy. In acute leukemia, the choice of drug therapy is limited. Steroids, of course, are the first thought, and are both supportive and suppressive in their action. Aminopterin is contraindicated in the first trimester because of its abortifacient properties; 6-MP carries a

similar, but lesser risk, and is probably the antimetabolite of choice when one must be used.

There is unanimous agreement in the literature that the placenta is an insuperable barrier to leukemia on either side. Although there have been a few reports of congenital leukemia, the mothers in all cases were normal, and no infant born of a leukemic mother has showed evidence of leukemia. As Bierman has pointed out[14], long term follow-up on these children is almost totally lacking, but thus far no late effects have been reported. In the many cases of leukemia in pregnancy in which the placenta, fetus or both have been examined pathologically, no leukemic cells have been found in the fetal organs or any part of the fetal circulation, even where the maternal side of the placenta was heavily infiltrated. Total lack of evidence or even speculation to explain this remarkable phenomenon is mute evidence of our complete ignorance of its mechanism. We know that blood cells pass through the placenta to cause sensitivity to Rh and other factors. We also know that certain hormones pass freely through the placenta. An extract of placenta from a case of chronic leukemia produced a definite myeloid infiltration in the organs of guinea pigs[15]. Yet no human fetus has shown a similar reaction when its mother has leukemia. In AK mice, lymphoid leukemia has been transmitted from one generation to the next by injecting a cell-free extract of leukemic organs into mice in the suckling stage[16]. Yet there is no transmission of human leukemia from one generation to the next. The nature of the placental barrier to transmission of leukemia, which seems absolute, is still a mystery which is not well explained by any of the theories of the origin of leukemia.

Summary

A previously unreported case of chronic myeloid leukemia complicated by pregnancy has been presented, and the literature pertinent to maternal and infant survival briefly surveyed. In acute leukemia, maternal survival time has increased and fetal mortality has considerably decreased in recent years. Comparable data are lacking in chronic leukemia. There is no evidence that the course of leukemia is affected by pregnancy. Treatment of leukemia during pregnancy should be conservative. Leukemia is not an indication for abortion, and only in rare instances is cesarean section indicated. Recent experience indicates that, when necessary, certain antileukemic therapy can be carried out during the pregnancy with no apparent harm to the fetus. The placenta is an absolute barrier to leukemia, and its mechanism is unknown. •

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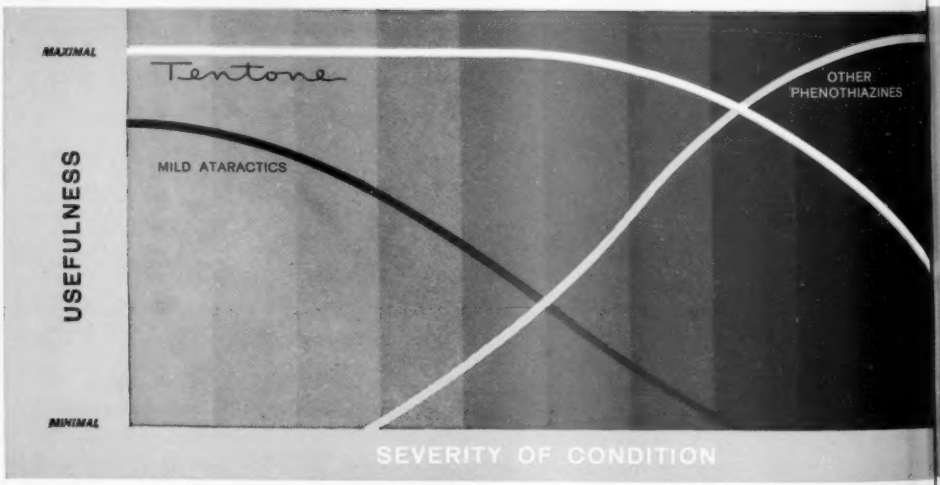
Comparison of TENTONE usefulness



THE WASHINGTON SCENE

A monthly news summary from the nation's capital by the Washington Office of the A.M.A.

President Eisenhower's power of veto has been a powerful weapon in his fight against big spending programs of the Democrats.

His outstanding use of the power so far in this session of Congress was the veto of the Democratic, catch-all $1,375,000,000 housing bill. Mr. Eisenhower said the measure was extravagant and inflationary. He warned that the fight against inflation could not be won "if we add one spending program to another without thought of how they are going to be paid for and invite deficits in times of general prosperity."

The housing bill included three provisions of interest to the medical profession. One provision, endorsed by the American Medical Association, would have authorized Federal Housing Administration guarantees of loans for construction of proprietary nursing homes. The second provision would have authorized direct federal loans for housing for interns and nurses. The third would have authorized both such loans and guarantees for housing for elderly persons.

Mr. Eisenhower objected to direct loans for the aged. But he directed his main attack against the legislation's public housing and urban renewal provisions.

The President also vetoed a wheat price support bill which, he charged, "would probably increase . . . the cost of the present excessively expensive wheat program."

The threat of a veto also caused the Democrats to retreat and cut back their airport construction legislation.

These actions improved prospects for a balanced, or near-balanced, budget in the current fiscal year. Another factor working for a balanced budget is the economic upsurge which means more federal revenue than originally estimated.

But Congress voted more for medical research than the President wanted. However, all of it may not be spent because the President has the authority to hold back part of it.

The Senate voted $481 million and the House, $344 million, for the National Institutes of Health —as against $294 million requested by Mr. Eisenhower. It was mandatory that a House-Senate Conference Committee, in working out a compromise between the House and Senate figures, approve a larger amount than the President requested.

The House Ways and Means Committee held

hearings on the controversial Forand bill which would finance medical and hospital care of the aged through the Social Security system. Witnesses for the medical profession vigorously opposed the legislation. Dr. Leonard Larson, Chairman of the A.M.A. Board of Trustees, and Dr. Frederick C. Swartz, Chairman of the A.M.A. Committee on Aging, presented the A.M.A.'s views.

Representatives of various state medical societies either testified or presented statements in opposition to the legislation which would be financed through higher Social Security taxes and which would cost about $2 billion a year.

On another legislative front, A.M.A. witnesses —Dr. George M. Fister, a member of the A.M.A. Board of Trustees and Chairman of the A.M.A. Council on Legislative Activities, and Dr. Vincent W. Archer, a member of the A.M.A. House of Delegates and the A.M.A. Committee on Federal Medical Services—testified before the Senate Finance Committee in support of a House-approved bill (Keogh-Simpson) that would provide tax deferrals for self-employed persons who invest in qualified pension or retirement plans.

Experts from 17 nations gave favorable reports on use of live polio virus vaccine at a week's conference sponsored by the World Health Organization and the Pan American Health Organization.

However, the 61 experts conceded in a statement summarizing the conference discussions that problems remain in use of the vaccine which is given orally. Their main concern was with "the very difficult problems in the development control and evaluation of the safety and effectiveness" of the live vaccine.

An advisory committee of the U. S. Public Health Service recommended a fourth shot of Salk polio vaccine as routine for children and adults under 40 years of age. The report also said that Salk vaccine shots could be beneficial for persons over 40 but was "less urgent" because they had polio less frequently than younger people.

Surgeon General Leroy E. Burney of the Public Health Service also issued an urgent warning that tragic polio outbreaks might occur this year if communities didn't push polio vaccination campaigns.

The Medical Society of the District of Columbia adopted a relative value scale of fees expressed in units rather than dollars. The basic unit of 1.0 is a routine office visit. The other relative values for medical services are multiples of the basic unit. For example—an appendectomy, 30 units; allergy skin tests, 2.0 units per 10 tests with a maximum of 15 units for multiple tests; anesthesia, first half-hour or any fraction thereof, 4.0 units.

It is not mandatory that the District Medical Society members charge fees conforming to the relative value scale.

The A.M.A. House of Delegates unanimously approved last year the study of relative value scales by state medical societies.

TENTH BIENNIAL

Rocky Mountain Medical Conference

A joint enterprise of

The Colorado State Medical Society
The Montana State Medical Association
The New Mexico Medical Society
The Utah State Medical Association
The Wyoming State Medical Society

combined with the

89th Annual Session of the Colorado State Medical Society

September 8, 9, 10, 11, 1959

SHIRLEY-SAVOY HOTEL
Denver, Colorado

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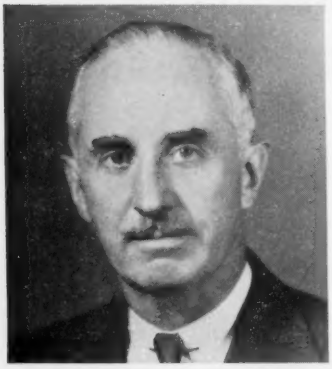
Chief, Medical Service,
The Lankenau Hospital, Philadelphia

FRED C. D. COLLIER, M.D.
Birmingham, Alabama
Professor of Surgical Pathology,
University of Alabama Medical Center



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DANELY P. SLAUGHTER, M.D.
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Professor of Surgery,
University of Illinois School of Medicine

THE ROCKY MOUNTAIN MEDICAL CONFERENCE

What It Is — What It Does

The Rocky Mountain Medical Conference is a biennial conference, a self-sustaining joint enterprise of five state medical societies. It was first suggested in 1935 by Dr. George P. Lingenfelter, Colorado's fraternal delegate to New Mexico, Utah, and Wyoming. Colorado, Utah, and Wyoming jointly decided to undertake such a conference, and New Mexico joined within a year. The first meeting was held in 1937 in Denver, with the Colorado Society as host. At that meeting permanent policies were fixed for the future of the Conference, and these policies have been adhered to ever since. Montana joined the Conference in 1939 at the time of the second meeting in Salt Lake City.

The basic principle and sole purpose of the Conference is to meet every two years to bring Rocky Mountain physicians together for an outstanding scientific program — and to bring them together for renewal of their regional friendships. The scientific program features speakers of national stature from outside the Rocky Mountain Region, and the meeting place of the Conference is rotated among the participating states. The Conference *does not* elect officers, indulge in medical politics, consider any resolutions or pronouncements relating to the policies of organized medicine, and forbids itself any activities that would aggrandize an individual, state or locality.

Management of the Conference is vested in a "Continuing Committee." Each participating State Medical Society has organized a Conference Committee of five of its members, serving overlapping five-year terms. These committees, together, constitute the Continuing Committee, which meets at least annually to plan future programs and manage the affairs of the Conference. The chairman of the host state's Conference Committee is Chairman of the Conference to be held in that state. He selects a Secretary-Treasurer for that particular meeting and with the help of the Continuing Committee also selects any subcommittees that may be needed to plan the meeting for which his state is host.

Originally, the Rocky Mountain Medical Conference met at times separate and distinct from the annual sessions of the participating states. In the years since World War II, with an ever increasing number of medical meetings, it has become customary for the host state to merge its own "state meeting" with the Conference and conduct the Conference at the season usually reserved for its own meeting.

REGISTRATION AT R.M.M.C.

Registration at the Rocky Mountain Medical Conference is open to any Doctor of Medicine. Registration is not limited to physicians within the five states which participate in managing the Conference.

The registration fee for the tenth meeting of the Conference at Denver is five dollars. The registration fee does not apply to members of the physician's family who may accompany him to the meeting, to guest speakers from outside the five-state area, or to properly accredited postgraduate residents or interns. Each physician will be given an identification badge, and admission to all Conference activities will be by badge only. Separate tickets will be on sale at the registration desk for the banquet and dance.

THE R.M.M.C. RUNS BY THE CLOCK!

The Scientific Programs of the Rocky Mountain Medical Conference are run by the clock, to the minute. This has been true of the previous meetings, and it will be true this September.

All meetings will begin on time, all speakers will be required to begin their presentations exactly on time and none will be permitted to speak longer than as scheduled in the program. All who attend the Conference are requested to assist the speakers and benefit themselves by being in the meeting room a few minutes in advance of the papers they wish to hear. Any member who arrives late to hear any particular paper is assured that he will miss part of that paper! Also, his late arrival would be disturbing to the speaker and the audience alike.

HOTEL RESERVATIONS

All major downtown hotels in Denver have set aside blocks of rooms to accommodate doctors and their families attending the Rocky Mountain Medical Conference. Reservations for the Conference should be made direct to the hotel or motel of your choice.

All members in the five-state area will soon receive a letter giving full details of hotel rates.

POCKET PROGRAM

A final program for the Tenth Rocky Mountain Medical Conference, complete with additional details not available for the Program Number of the Journal, will be published in pocket size in August and mailed to all members of the participating State Medical Societies.

ENTERTAINMENT

The preliminary program in this issue of the Journal shows there will be a Stag Dinner and Smoker in the Lincoln Room of the Shirley-Savoy Hotel on Tuesday evening, September 8, this being actually the evening before the opening of the Conference. This evening was chosen for the Stag Dinner since most doctors will wish to arrive in Denver that day, not only to be on hand for the first guest speaker the next morning, but in many instances in order to participate in the Tuesday afternoon sports events or to listen to the proceedings of the Colorado House of Delegates.

Simultaneous with the Stag Party there will be a special "Femme Fare" staged by the Woman's Auxiliary of the Colorado State Medical Society, to which all doctors' ladies from the other participating states are invited. Details of this and other entertainment will be announced in the final program to be mailed in August.

SPORTS EVENTS

All golfers attending the R.M.M.C. should be sure to bring their clubs and be on hand in time to take part in a tournament being held promptly at 2:00 p.m., Tuesday, September 8. There will also be a bowling tournament and a trap and skeet shoot, so keglers and shotgun artists should also take note. As this Program Issue of the Journal goes to press, the committees have not made definite selection on which country club in Denver to use, but full details will appear in the final program. Prizes for each sports event will be awarded at the Stag Dinner in the Shirley-Savoy Hotel that same evening.

BANQUET AND DANCE

A banquet and dance has been arranged for all attending the R.M.M.C. by the Woman's Auxiliary of the Colorado State Medical Society to be held in the Grand Ballroom of the new Brown Palace West Hotel. An excellent entertainment program by professionals will be presented, and we urge you to make plans early to attend. Mark your calendar for Thursday evening. Cocktail hour at 6:30 and dinner at 7:30. Tickets will be on sale at the registration desk, but only until Thursday noon.

WOMAN'S AUXILIARY PROGRAM

Full details of the activities scheduled by the Auxiliary will be carried in the pocket program.

PROGRAM

Biennial ROCKY MOUNTAIN MEDICAL CONFERENCE

Shirley-Savoy Hotel - Denver, Colorado

September 8, 9, 10, 11, 1959

Joint Activities, R.M.M.C. and Colorado

Tuesday, September 8

R.M.C. ACTIVITIES:

All Day Installation of Exhibits.

8:00 a.m. **Registration opens,** Empire Room of the Shirley-Savoy Hotel.

NOTE: For the convenience of members of the Colorado House of Delegates, a special registration desk will be operated on the Promenade of the Brown Palace West Hotel.

2:00 p.m. **Sports Events.** Golf Tournament, Bowling, Trap and Skeet Shoot; prizes to be offered. Location and details to be published in the final pocket program.

6:30 p.m. **Femme Fare** — watch for details in the final pocket program.

6:30 p.m. Stag Dinner, entertainment and smoker; Lincoln Room, Shirley-Savoy Hotel. Details to be announced in final pocket program.

COLORADO ACTIVITIES:

8:00 a.m. **Orientation Course** for New Members, Denver Medical Society Building, 1601 E. 19th Avenue (19th Avenue at Franklin Street). Course continues through luncheon and adjourns at 1:30 p.m.

10:00 a.m. **House of Delegates,** first meeting of Annual Session; Ballroom of Brown Palace West Hotel.

Wednesday, September 9

Obstetrics, Gynecology and Pediatrics

MORNING

JOHN ZARIT, M.D., President, Colorado State Medical Society, *Presiding*

8:00 a.m. Registration and all Exhibits Open.

9:30 a.m. Perinatal Mortality — Every Physician's Concern — **M. Edward Davis, M.D., Chicago (Guest).**

10:00 a.m. Changes in Circulation and Biochemical Readjustment of the Newborn — **L. Stanley James, M.D., New York (Guest).**

10:30 a.m. Intermission to visit Exhibits.

11:00 a.m. Diagnosis and Management of Preinvasive Carcinoma of the Cervix in Pregnant and Non-Pregnant Patients — **Ben M. Peckham, M.D., Madison (Guest).**

11:30 a.m. Question and Answer Period and Panel Discussion.

12:00 noon Adjourn for Lunch.

AFTERNOON

ULRICH R. BRYNER, M.D., President, Utah State Medical Association, *Presiding*

Closed-circuit full-color Television Surgical Clinics on Ob-Gyn and Pediatrics.

2:00 to 4:00 p.m. *Direct telecast of medical and surgical procedures from St. Joseph's Hospital to special receivers in the Lincoln Room of the Shirley-Savoy Hotel through cooperation of Smith, Kline and French Laboratories.*

Moderators:

Wilbur Manly, M.D. — Shirley-Savoy Hotel

Harold Palmer, M.D. — St. Joseph's Hospital

Case Presentation — Harold Palmer, M.D., Denver.

Caesarean Section — Ben Williams, M.D., Denver.

Demonstration and discussion on **Resuscitation of the Newborn** — L. Stanley James, M.D., New York (Guest).

Obstetrical Complications Contributing to Resuscitation Problems of the Newborn — Ben M. Peckham, M.D., Madison (Guest).

Demonstration of an Exchange Transfusion — Peter Hoch, M.D., Denver.

The Obstetrical Aspects of Erothroblastosis — M. Edward Davis, M.D., Chicago (Guest).

Pediatric Problems Related to Erythroblastosis — L. Stanley James, M.D.

4:30 p.m. Colorado House of Delegates — Second Meeting — Brown Palace West Hotel.

Thursday, September 10

Hematology and Lymphomas

MORNING

BENJAMIN GITLITZ, M.D., President-elect, Wyoming State Medical Society, *Presiding*

8:00 a.m. Registration and Exhibits Open.

9:00 a.m. Surgery of Lymphomas — **Danely P. Slaughter, M.D., Chicago (Guest).**

9:30 a.m. Present Status of Chemotherapy of the Leukemias and the Lymphomas — **Harold W. Dargeon, M.D., New York (Guest).**

10:00 a.m. Present Concept of Diagnosis and Interrelationships of the Leukemias and Lymphomas — **Fred C. D. Collier, M.D., Birmingham (Guest).**

10:30 a.m. Intermission to visit Exhibits.

11:00 a.m. Present Status of Radiation Therapy of the Lymphomas — **L. Henry Garland, M.D., San Francisco (Guest).**

11:30 a.m. **Question and Answer Period and Panel Discussion** — George Curfman, M.D., Denver, Moderator.

12:00 noon Adjourn for Lunch.

AFTERNOON

LEWIS M. OVERTON, M.D., President, New Mexico Medical Society, *Presiding*

Closed-circuit full-color Television Surgical Clinics on Leukemias and Lymphomas.

2:00 to 4:00 p.m. Demonstration featuring the importance of impression smears, bacteriology, frozen sections, and proper fixation of tissue for permanent sections by W. H. Leitch, M.D., Denver. The frozen section made on the biopsied tissue will be reported to the panel for discussion.

Panel Discussion — Moderator: Wm. A. H. Rettberg, M.D., Denver.

Participants: Drs. Fred C. D. Collier, Birmingham; Harold Dargeon, New York; L. Henry Garland, San Francisco, and Danely P. Slaughter, Chicago.

Case Presentations.

EVENING

7:30 p.m. Banquet for the doctors and their wives in the Grand Ballroom of the Brown Palace West Hotel.

9:00 p.m.-12:00 p.m. Dancing.

Friday, September 11

A Day Devoted to Geriatrics

MORNING

HERBERT T. CARAWAY, M.D., President, Montana Medical Association, *Presiding*

8:00 a.m. Registration and Exhibits Open.

9:00 a.m. Medicine's Stake in Our Older Citizens — **Edward L. Bortz, M.D., Philadelphia (Guest).**

9:30 a.m. Emotional Problems of the Aging — **Jack Weinberg, M.D., Chicago (Guest).**

10:00 a.m. Intermission to visit Exhibits.

10:30 a.m. Must Time Take Its Toll? — **Theodore Klumpp, M.D., New York (Guest).**

11:00 a.m. **Question and Answer Period and Panel Discussion** — Herbert T. Caraway, M.D., President, Montana Medical Association, Moderator.

12:00 noon Adjourn for Lunch.

AFTERNOON

JOHN L. MCDONALD, M.D., Incoming President, Colorado State Medical Society, *Presiding*

Closed-circuit full-color Television on Care and Rehabilitation of the Older Patient.

2:00 to 4:00 p.m. **Panel — Hemiplegia** — *A patient who has had ischemic episodes followed by a "stroke"* — Drs. Robert S. Liggett, Gene M. Lasater, and Fred A. Lewis, Jr., all of Denver.

Panel — Emotionally Disturbed Elderly Patient — Drs. Franklin G. Ebaugh and James A. Galvin of Denver.

Panel — Arthritis — Drs. Charley Smyth, John Leidholt, and George Twombly, all of Denver.

SCIENTIFIC EXHIBITS

The Role of Radioactive Testosterone on Hematopoiesis — Martin J. Murphy, Jr.
Surgical Considerations of Vascular Disease — William R. Coppinger, M.D.
Elbow Fractures in Children — John D. Leidholt, M.D., Mack L. Clayton, M.D., and Lloyd Beber, M.D.
The Artificial Kidney — William Robb, M.D., and Joseph H. Holmes, M.D.
Ultrasonic Visualization of Human Soft Tissue Structures — Joseph H. Holmes, M.D., Douglass Howry, M.D., Richard Cushman, M.D., and Ralph Goble, M.D.
Neck Injuries — Ralph Stuck, M.D.
A.M.E.F. — Frank Stander, M.D.
Common Ocular Problems — Dan M. Gordon, M.D.
Meckel's Diverticulum — Wendell P. Stampfli, M.D.
Radiation in Advanced Cancer Cases—John S. Boulog, M.D.
The Colorado Safety Car — Horace E. Campbell, M.D.
The Diagnosis & Treatment of Hearing Loss — Will P. Pirkey, M.D.
Boulder County Breaks Polio Vaccine Barrier — Charles H. Dowding, Jr., M.D.
Diagnostic Problems in Pediatric Cardiology — Murray S. Hoffman, M.D., Ralph Shugart, M.D.
Water Supplies and Sewage Disposal Facilities — Miss Norma Johannis

TECHNICAL EXHIBITS

Abbott Laboratories
Aloe, A. S., Company
American Ferment Company, Inc.
Ames Company, Inc.
Audio-Digest Foundation
Ayerst Laboratories
Baker Laboratories, Inc., The
Beard, Glynn A.
Berbert and Sons, Inc., George
Burroughs Wellcome & Co. (U.S.A.), Inc.
Carnation Company
Ciba Pharmaceutical Products, Inc.
Coca Cola Company, The
Colorado Medical Service, Inc.
Darwin Laboratories
Denab Laboratories, Inc.
Eaton Laboratories
Edison, Thomas A., Inc.
Empire Casualty Company
Encyclopaedia Britannica
Fleet, C. B., Company, Inc.
Geigy Pharmaceuticals
General Electric Company, X-ray Dept.
Great Books of the Western World
Holland-Rantos Company, Inc.
Knoll Pharmaceutical Company
Lederle Laboratories Division, American Cyanamid Company
Lilly and Company, Eli
Marion Laboratories, Inc.
Marsengill, The S. E. Company
Mead Johnson and Company
Merck, Sharp and Dohme
Merrell Company, The William S.
Milex-Fertilex Company
Muckle Professional Equipment Company
Mullen, The J. K. Investment Company
Ortho Pharmaceutical Corporation
Parke, Davis and Company
Picker X-ray, Rocky Mountain Inc.
Robins Company, Inc., A. H.
Roche Laboratories
Ross Laboratories
Sandoz Laboratories
Saunders Company, W. B.
Schering Corporation
Searle and Company, G. D.
Smith, Kline, and French Laboratories
Squibb and Sons, E. R.
Technical Equipment Corporation
Warner Chilcott Laboratories
Winthrop Laboratories

ROCKY MOUNTAIN MEDICAL CONFERENCE

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CONTINUING COMMITTEE

COLORADO: George P. Lingenfelter, Denver, Chairman; H. Calvin Fisher, Denver; Fred Kuykendall, Eaton; William M. Covode, Denver; H. Harper Kerr, Pueblo.

MONTANA: Thomas W. Saam, Butte, Chairman; Deane C. Epler, Bozeman; Donald O. Schultz, Helena; Arthur J. Movius, Jr., Billings; Stephen N. Preston, Missoula.

NEW MEXICO: Aaron E. Margulis, Santa Fe, Chairman; Andrew M. Babey, Las Cruces; Charles R. Beeson, Albuquerque; V. E. Berchtold, Santa Fe; Wesley O. Connor, Jr., Albuquerque.

UTAH: Richard P. Middleton, Salt Lake City, Chairman; Jesse J. Weight, Provo; R. N. Hirst, Ogden; T. E. Robinson, Salt Lake City.

WYOMING: James W. Barber, Cheyenne, Chairman; Frederick H. Haigler, Casper; Paul R. Yedinak, Rock Springs; John H. Froyd, Worland; Joseph S. Hellewell, Evanston.

SCIENTIFIC PROGRAM

William M. Covode, Denver, Chairman; Harold Palmer, Denver; C. Wesley Eisele, Denver; George M. Horner, Denver; Robert Patterson, Loveland; Lester L. Williams, Colorado Springs; L. Clark Hepp, Denver; H. Calvin Fisher, Denver.

SUBCOMMITTEE ON MEN'S ENTERTAINMENT AND SPORTS EVENTS

Robert G. Bosworth, Denver, Chairman; Darius W. Darwin, Boulder; John C. McAfee, Denver; Michael Bograd, Denver; Robert B. Patterson, Loveland.

SUBCOMMITTEE ON BANQUET AND LADIES' ENTERTAINMENT

Mrs. Harry C. Hughes, Chairman; Mrs. Dean W. Hodges; Mrs. Donald H. Perkin; Mrs. William A. H. Rettberg; Mrs. Lloyd V. Shields; Mrs. William F. Stanek, Jr.; all of Denver.

PUBLICITY SUBCOMMITTEE

John S. Bouslog, Denver, Chairman; Robert E. McCurdy, Denver; Raymond F. Peterson, Butte; Andrew M. Babey, Las Cruces; R. M. Hirst, Ogden; James W. Barber, Cheyenne.

HOSPITALITY SUBCOMMITTEE

H. Harper Kerr, Pueblo, Chairman; Harold W. Gregg, Butte; Wesley O. Connor, Jr., Albuquerque; T. E. Robinson, Salt Lake City; John H. Froyd, Worland.

SUBCOMMITTEE ON CONVENTION FACILITIES AND TECHNICAL EXHIBITS

Mr. Harvey T. Sethman, Colorado; Mr. L. R. Hegland, Montana; Mr. Ralph R. Marshall, New Mexico; Mr. Harold Bowman, Utah; Mr. Arthur Abbey, Wyoming.

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Delegates will find themselves just as busy as at any previous state meeting. Watch for the House of Delegates Handbook, the final Program, and other notices later this month. Reserve Sept. 8 to 11, inclusive, sure!

WYOMING

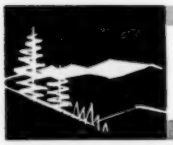
Some of the new officers of the Wyoming State Medical Society with outgoing President Wilmoth. Left to right: Past President L. H. Wilmoth, M.D.; President Benjamin Gitlitz, M.D.; President-elect Francis Barrett, M.D.; Vice President S. J. Giovale, M.D. Not shown: Treasurer C. D. Anton, M.D.; Secretary Frederick H. Haigler, M.D.

Obituary

PHILIP SHERIDAN PAWLING

Philip Sheridan Pawling, M.D., 79, expired May 27, 1959, at the Wyoming State Hospital, Evanston, Wyoming. Dr. Pawling was born September 2, 1879, at Hilliards, Ohio. He was licensed in Wyoming May 1, 1919, and practiced in Evanston and Rock Springs, Wyoming.

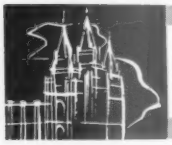
Dr. Pawling had been in ill health for several years. According to our records, there are no survivors.



COLORADO

Delegates and Committeemen; note:

By vote of the House two years ago, the Rocky Mountain Medical Conference is presenting the Scientific Program for your Annual Session next month (see Program, pages 71 to 78). However, all committees and all members of the House of



UTAH

Sixty-Fourth Annual Scientific Sessions Utah State Medical Association

Program on pages 82, 83, 86, 87.

Obituary

LESLIE S. MERRILL

Leslie S. Merrill, M.D., 67, retired Ogden physician, died June 17 in St. Benedict's Hospital.

Dr. Merrill was born February 8, 1892, in Franklin, Idaho, a son of Marriner Wood and Eliza Lucina Shepard Merrill, Jr. On July 6, 1916, he married Eliza Deal in Chicago. She died in January, 1918, in Provo. He married Stella Petersen on June 8, 1921, in the Salt Lake LDS Temple.

Dr. Merrill received his B.A. degree from the University of Utah in 1914 and his M.D. degree from Western Reserve University, Cleveland, in 1917. He served his internship in the Cleveland City Hospital and was with the Army Medical Corps during World War I. After his discharge he practiced in Bingham for a short time before going to Ogden. He retired in 1953 due to illness.

He was a member of the Weber County Medical Society, Utah State Medical Association, American Medical Association, and Fellow American College Surgeons.

Surviving are his widow, a son and daughter, three grandchildren, and three sisters.

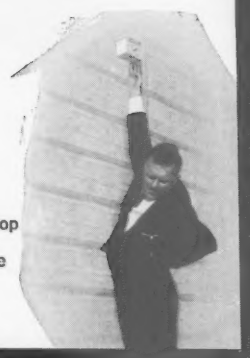
Symposium on Evaluation of Early Diagnosis of Cancer

The American Cancer Society announced the presentation of a Symposium on Evaluation of Early Diagnosis of Cancer, October 26-27, 1959, in the Biltmore Hotel, New York.

Many distinguished physicians will present papers on this subject and subjects closely allied to the program theme. Thought provoking panel sessions will follow morning and afternoon presentation of papers.

For further information, please write Scott Hill, M.D., Director of Professional Education, American Cancer Society, Inc., 521 West 57th Street, New York 19, N. Y.

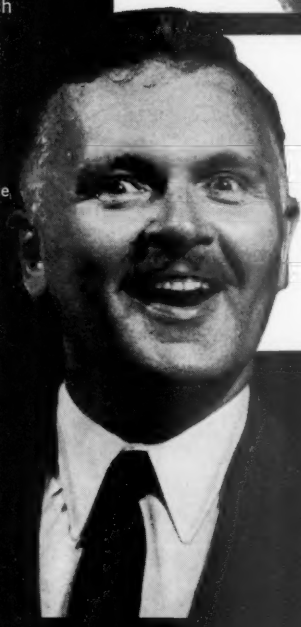
REACHING FOR THOSE 9B's NEARLY PUT ME ON THE SHELF...



Reaching for 9B shoes and other top shelf sizes is no joke . . . it gave me a terrible kink in my back.

Before the day was over, I could hardly stoop to push a shoehorn.

I called my doctor that night and picked up the tablets he prescribed.



The pain went away fast—in just 15 minutes—and I was back on the job the next morning! But not one 9B customer came in the whole day!

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AVERAGE ADULT DOSE: 1 tablet every 6 hours. May be habit-forming. Federal law permits oral prescription.

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Sixty-Fourth Annual Scientific Sessions

of the

Utah State Medical Association

September 16, 17, 18, 1959 . . . Hotel Utah Motor Lodge

Wednesday, September 16

Morning

9:00—Registration (all day)

Afternoon

1:15—Welcoming address and presiding: U. R. Bryner, M.D., President

1:30—"The Diagnosis and Treatment of Hyperthyroidism—Current Concepts," Jack B. Trunnell, M.D., Provo

2:00—"Clinical Studies in Older Patients," Edward L. Bortz, M.D., Philadelphia

2:30—"A Concept of the Basic Mechanism of the Rheumatic Diseases," Thomas McPherson Brown, M.D., Washington, D. C.

3:30—"Iron Deficiency Anemia in Infants," M. Eugene Lahey, M.D., Salt Lake City

4:00—Symposium, "Newer Adrenocorticosteroids." Moderator: Frank H. Tyler, M.D. Members: Gerald T. Perkoff, M.D.; John R. Ward, M.D.; Dean Spear, M.D.; William J. Morginson, M.D.

Evening

6:00—Blue Shield Reception, "House of Friendship," Newhouse Hotel

7:00—Annual Dinner Meeting, Blue Shield Stockholders, Newhouse Hotel

Thursday, September 17

Morning

Presiding: I. Bruce McQuarrie, M.D., President-elect

8:00—Movies, "M.D. International"

9:00—"Nutritional and Psychological Factors in Atherogenesis," Jack B. Trunnell, M.D.

9:30—"Changing Concepts in Preoperative Medication," C. R. Stephen, M.D., Durham, North Carolina

10:00—"The Evaluation and Treatment of Lesions of the Cervix," J. Robert Willson, M.D., Philadelphia

11:00—"The Emerging Older Man," Edward L. Bortz, M.D.

11:30—"Gastrointestinal and Other Somatic Manifestations of Rheumatoid Disease," Thomas McPherson Brown, M.D.

12:10—Luncheon, Empire Room, Hotel Utah. Informal Panel Discussion. Moderator: John F. Waldo, M.D., Salt Lake City. Panel Members: Edward L. Bortz, M.D.; Thomas McPherson Brown, M.D.; C. R. Stephen, M.D.; Jack B. Trunnell, M.D.; J. Robert Willson, M.D.

Afternoon

Presiding: Benjamin Gitlitz, M.D., President, Wyoming State Medical Society

2:00—"Portal Hypertension in Infants and Children," M. Eugene Lahey, M.D.

2:30—"The Role of Staphylococci in External Ocular Disease," Phillips Thygeson, M.D., San Francisco

3:00—"Primary Care of Hand Injuries—Current Concepts," J. William Littler, M.D., New York City

4:00—"Management of Infections of the Urinary Tract," John L. Emmett, M.D., Rochester

4:30—Report on the Second Annual Workshop on Mental Health, Carlos N. Madsen, M.D., Chairman, Mental Health Committee

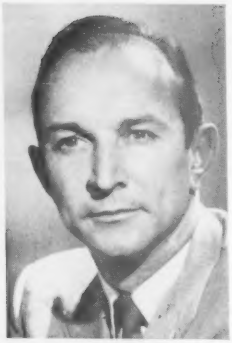
Evening

Attend one of the specialty group dinners. You

Edward L. Bortz, M.D.
Philadelphia

Thomas McP. Brown, M.D.
Washington, D. C.

John L. Emmett, M.D.
Rochester



M. Eugene Lahey, M.D.
Salt Lake City

GUEST SPEAKERS

Edward L. Bortz, M.D., Past President, American Medical Association, Chief, Medical Service, The Lankenau Hospital, Philadelphia, Pennsylvania.

Thomas McPherson Brown, M.D., Eugene Meyer Professor of Medicine, Department of Medicine, George Washington University School of Medicine, Washington, D. C.

John L. Emmett, M.D., Professor of Urology, Mayo Foundation Graduate School, University of Minnesota, Consultant in Urology, Mayo Clinic, Rochester, Minnesota.

M. Eugene Lahey, M.D., Professor and Head, Department of Pediatrics, University of Utah College of Medicine, Salt Lake City, Utah.

J. William Littler, M.D., Chief, Plastic and Reconstructive Surgery, Roosevelt Hospital, New York City, New York.

Reginald H. Smithwick, M.D., Professor and Chairman, Department of Surgery, Boston University School of Medicine, Surgeon-in-Chief, Massachusetts Memorial Hospitals, Boston, Massachusetts.

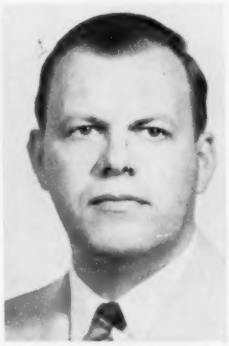
C. R. Stephen, M.D., Professor of Anesthesiology, Duke University Medical Center, Durham, North Carolina.

Phillips Thygeson, M.D., Clinical Professor of Ophthalmology, University of California Medical Center, San Francisco, California.

continued on page 86

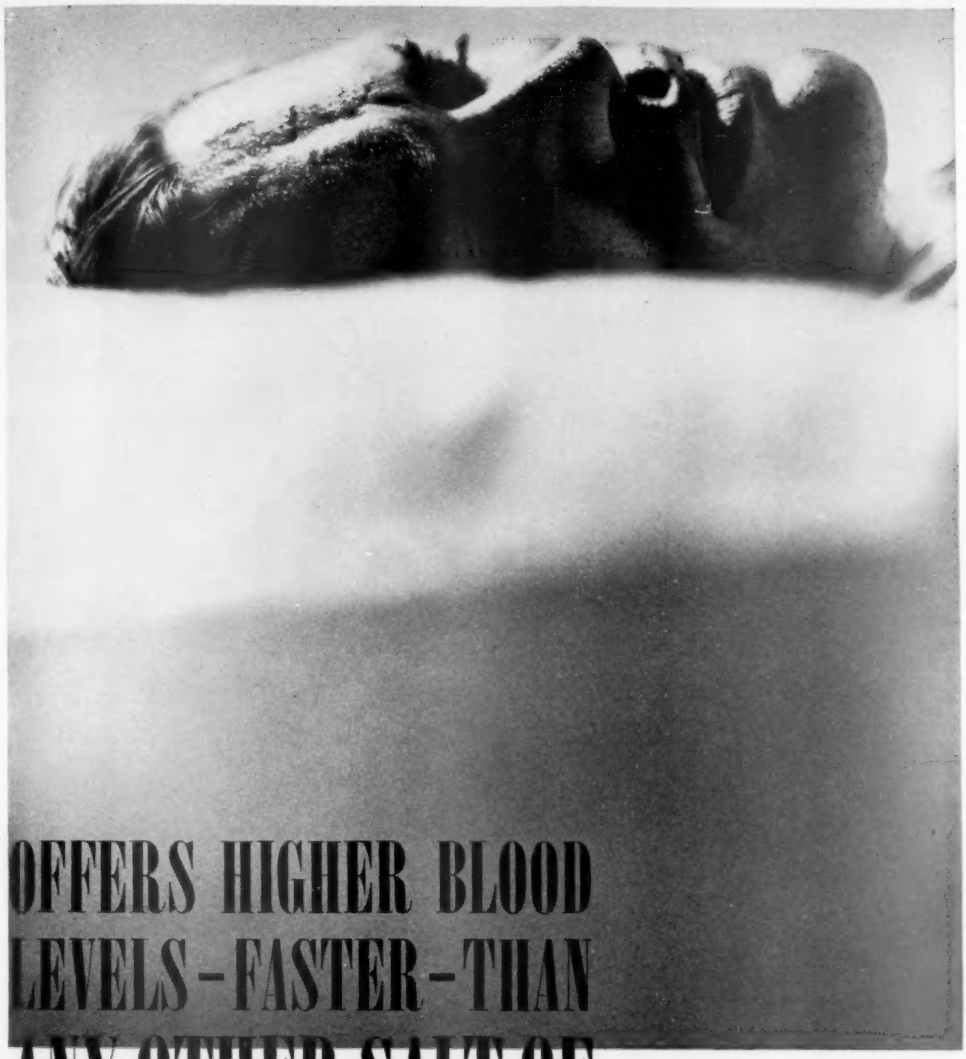
J. William Littler, M.D.
New York

Reginald H. Smithwick, M.D.
Boston



C. R. Stephen, M.D.
Durham

Phillips Thygeson, M.D.
San Francisco



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Organization cont. from page 83

Jack B. Trunnell, M.D., Dean, College of Family Living, Brigham Young University, Provo, Utah.

J. Robert Willson, M.D., Professor and Chairman, Department of Obstetrics and Gynecology, Temple University School of Medicine, Philadelphia, Pennsylvania.

Jack B. Trunnell, M.D.
Provo

J. Robert Willson, M.D.
Philadelphia

Guest Speakers

are invited to attend the dinner meeting of your choice, regardless of your specialty.

Intermountain Pediatric Society; Wright's Restaurant; 6:30 p.m., social hour; 8:00 p.m., dinner.

Salt Lake Surgical Society; Salt Lake Country Club; 6:00 p.m., social hour; 7:00 p.m., dinner.

Utah Chapter, American Academy of General Practice; Fort Douglas Club; 6:30 p.m., social hour; 7:30 p.m., dinner.

Utah Society of Internal Medicine; University Club; 6:30 p.m., social hour; 7:30 p.m., dinner.

Utah Obstetrical and Gynecological Society; Ambassador Club; 7:00 p.m., social hour; 8:00 p.m., dinner.

Intermountain Oto-ophthalmological Society; University Club; 6:00 p.m., social hour; 7:00 p.m., dinner.

Utah Society of Anesthesiologists; Salt Lake Country Club; 5:30 p.m., social hour; 6:30 p.m., dinner.

Utah State Radiological Society; Ambassador Club; 6:30 p.m., social hour; 7:30 p.m., dinner.

Friday, September 18

"SURGERY DAY"

Morning

Presiding: Wesley W. Hall, M.D., F.A.C.S., Nevada A.M.A. Delegate

8:00—Movies: "Moles and Melanomas," "Tumors of Childhood"

9:00—"Ocular Syndromes of General Interest," Phillips Thygeson, M.D.

9:30—"Evaluation of Endocrine Management of Carcinoma of the Prostate Gland," John L. Emmett, M.D. Sponsored by the Utah Division of The American Cancer Society.

10:00—"Hypertension of Adrenal and Renal Origin," Reginald H. Smithwick, M.D., Boston

11:00—Symposium, "Basic Principles and Care of Hand Injuries." Moderator: T. Ray Broadbent, M.D., Salt Lake City. Members: Mark H. Greene, Jr., M.D.; J. William Littler, M.D.; R. R. Robinson, M.D.; Robert M. Woolf, M.D.

12:10—Luncheon, Empire Room, Hotel Utah. Informal surgical panel discussion. Moderator: C. Charles Hetzel, Jr., M.D., Ogden. Panel Members: John L. Emmett, M.D.; Phillips Thygeson, M.D.; Reginald H. Smithwick, M.D.; J. William Littler, M.D.; T. Ray Broadbent, M.D.

Afternoon

Presiding: George M. Fister, M.D., Ogden, Trustee to the A.M.A.

2:00—"What Anesthetic Shall I Choose Today?" C. R. Stephen, M.D.

2:30—"The Evaluation of Bleeding During Late Pregnancy," J. Robert Willson, M.D.

3:30—"Splanchniectomy in the Management of Essential Hypertension," Reginald H. Smithwick, M.D.

4:00—"The Severed Flexor Tendon," J. William Littler, M.D.

4:30—"Hernias—Better Results," Vincent L. Rees, M.D., Salt Lake City

5:00—Close of the Scientific Program

Evening

6:00-7:15—President's Reception, Alta Club

7:30—President's Banquet, Lafayette Ballroom, Hotel Utah. Speaker: Louis M. Orr, M.D., President, American Medical Association—"Medicine Is Not Failing America"

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avoid the risk of insoluble, irritating aspirin particles

Chief among the drawbacks to aspirin usage is gastric intolerance. This ranges from mild upset and "heartburn" to severe hemorrhagic gastritis.[1-10] Studies performed in conjunction with gastrectomy[4, 5] and gastroscopy[2] have shown insoluble aspirin particles firmly adherent to the gastric mucosa and imbedded between rugae. Reactions varying from mild hyperemia to erosive gastritis have been reported to occur in the areas immediately surrounding these adherent particles.[2, 4, 5] This is reported to be particularly true in patients with peptic ulcer.[4]

CALURIN is the freely soluble, stable calcium aspirin complex. Its high solubility forestalls gastric irritation or damage

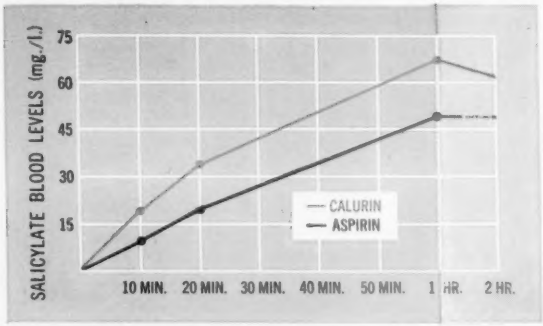
Regular aspirin crystals 24 hours after being mixed into water.

Calurin crystals in solution one minute after being mixed into water.

CALURIN*

STABLE SOLUBLE CALCIUM-ACETYLSALICYLATE-CARBAMIDE

Particle-induced ulceration — section through lesion found in gastrectomy specimen. An aspirin particle was found firmly imbedded in this undermined erosion. Such lesions may be associated with the relative insolubility of aspirin, which remains in particulate form after dispersion in gastric contents.



Calurin, being freely soluble, is promptly available for absorption into the systemic circulation. Salicylate blood levels in 12 subjects receiving both Calurin and plain aspirin were found to rise more than twice as high within ten minutes following Calurin. Also, these levels persisted higher for at least two hours.[11]

CALURIN is the aspirin of choice, especially when high-dosage, long-term therapy is indicated:

1. High solubility forestalls gastric irritation or damage. This advantage is of special importance in arthritis and other conditions requiring high-dosage, long-term therapy.
2. Produces high salicylate blood levels rapidly for prompt analgesic, antipyretic, anti-arthritic effect.
3. Sodium-free — for safer long-term therapy.
4. Flavored: can be chewed or dissolved in the mouth without water if desired — an advantage for patients requiring aspirin administration during the night and for pediatric patients.

Dosage: Each tablet of Calurin is equivalent to 300 mg. (5 gr.) of acetylsalicylic acid. For relief of pain and fever in adult patients, the usual dose of Calurin is 1 to 3 tablets every 4 hours, as needed; in arthritic states, 2 or 3 tablets 3 or 4 times daily; in rheumatic fever, 3 to 5 tablets 4 or 5 times daily. For children over 6 years, the usual dose is 1 tablet every 4 hours; for children 3 to 6 years, ½ tablet every 4 hours, as required. Not recommended for children under 3.

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*TRADEMARK

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska

NIAMID*

the mood brightener

Lifts the burden of depression... opens the way for a sunnier outlook

New areas of therapy

NIAMID is clinically effective in a broad range of depressive states, including: involutional melancholia, senile depression, postpartum depression, reactive depression, the depressive stage of manic-depressive disease, and schizophrenic depressive reaction.

A wide variety of psychoneurotic depressions seen in general practice also respond effectively to NIAMID. Depression associated with the menopause and with postoperative states, and depression accompanying chronic or incurable diseases such as gastrointestinal and cardiovascular disorders, arthritis, and inoperable cancer, can now be treated successfully with NIAMID.

NIAMID is also strikingly effective for many complaints, mild or severe, vague or well defined, when due to masked depression rather than to organic disease. This masked depression may take the form of guilt feelings, crying spells or sadness, difficulty in concentration, loss of energy or drive, insomnia, emotional fatigue, feelings of hopelessness or helplessness, loss of interest in normal activity, listlessness, apprehension or agitation, and loss of appetite and weight.

While tranquilizers have had some measure of effectiveness in many of these areas, NIAMID now gives the practicing physician a new, safe drug for the specific treatment of depression without the risk of increasing the depressive symptoms.

New safety

The outstanding safety of NIAMID in extensive clinical trials eliminates the hepatotoxic reactions observed with the first of the monoamine oxidase inhibitors. These reactions have not been seen with NIAMID.

Acute and chronic toxicity studies show this distinctive freedom from toxicity. Moreover, during the extensive clinical trials of NIAMID by a large number of investigators, not only has no liver damage been reported, but only in a very few isolated instances have hypotensive effects been seen.

The absence of toxicity may be the result of the unique carboxamide group in the NIAMID molecule. This structure may explain why NIAMID is excreted largely unchanged in the urine, with only insignificant quantities of potentially free hydrazine being formed. Previously, where a monoamine oxidase inhibitor had been associated with hepatic toxicity, there was some evidence that substantial quantities of free hydrazine were formed in the body.

Background of NIAMID

A major advance in the treatment of mental depression came with a newer understanding of the influence of brain serotonin and norepinephrine on the mood. Levels of both these neuro-hormones are decreased in animals under experimental conditions analogous to depression; relief of these model depressions is seen with a rise in the levels of both serotonin and norepinephrine.

A second advance came with the development of monoamine oxidase inhibitors, substances which raise the cerebral level of both serotonin and norepinephrine. The first of the amine oxidase inhibitors raised the cerebral level of serotonin, but did not appear to raise that of norepinephrine levels proportionately.

Pfizer *Science for the world's well-being™*

PFIZER LABORATORIES

Division, Chas. Pfizer & Co., Inc., Brooklyn 6, N. Y.

Attention at Pfizer Research was then directed to a new drug that would overcome this disadvantage. NIAMID significantly raises the cerebral level of *both* serotonin and norepinephrine under experimental conditions.

The dramatic discovery of NIAMID now makes available an extremely effective, safe antidepressant for the successful treatment of a full range of depressive states.

Precautions

Side effects are most often minor and mild manifestations of central nervous system stimulation, modifiable by reduction in dosage; these may take the form of restlessness, insomnia, headache, weakness, vertigo, dry mouth, and perspiration. Care should be taken when NIAMID is used with chlorothiazide compounds, since hypotensive effects have been noted in some patients receiving combined therapy—even though hypotension has rarely been noted with NIAMID alone. There has been no evidence of liver damage in patients on NIAMID; however, in patients who have any history of liver disease, the possibility of hepatic reactions should be kept in mind.

Dosage and Administration

Start with 75 mg. daily in single or divided doses. After a week or more, revise the daily dosage upward or downward, depending upon the response and tolerance, in steps of one or one-half 25 mg. tablet. Once satisfactory response has been attained, the dosage of NIAMID may be reduced gradually to the maintenance level.

The therapeutic action of NIAMID is gradual, not immediate. Many patients respond within a few days, others satisfactorily in 7 to 14 days. Some patients, particularly chronically depressed or regressed psychotics, may need substantially higher dosages (as much as 200 mg. daily has been used) and prolonged administration before responses are achieved.

Supply

NIAMID is available in: 25 mg., pink, scored tablets in bottles of 100; and 100 mg., orange, scored tablets in bottles of 100.

References

Complete bibliography and Professional Information Booklet are available on request.

*TRADEMARK FOR BRAND OF NIALAMIDE

NIAMID
the mood brightener

MONTANA

81st Annual Meeting
Montana Medical Association

Program on page 98.

The Montana Medical Association extends a cordial invitation to all physicians in the Rocky Mountain area to attend its 81st Annual Meeting in Butte, Thursday, Friday and Saturday, September 17, 18 and 19. All of the scientific sessions and business meetings will convene in the Silver Bow Room of the Finlen Hotel.

The House of Delegates of the Association will convene for its opening session at 8:30 a.m. on Thursday, September 17. At this session committee reports, resolutions and new business will be received and referred to the appropriate reference committee for study. The second session of the House of Delegates will convene at 3:45 p.m., Friday, September 18, and the final session at 1:30 p.m. on Saturday, September 19. The House of Delegates will recess its Saturday afternoon meeting to convene as the Administrative Body of Montana Physicians' Service. At the close of the meeting of the Administrative Body, it will reconvene for the election of officers.

On Wednesday afternoon, September 16, the Local Arrangements Committee of the Silver Bow County Medical Society, under the chairmanship of L. J. Rotondi, M.D., Butte, will sponsor a golf tournament for all physicians. This tournament will be held at the Butte Country Club, and physicians will be awarded prizes for the best scores. Those who enter the tournament are requested to bring their handicap from their home course.

On Thursday evening, September 17, the Montana Medical Association will sponsor its annual reception and banquet at the Finlen Hotel. Louis M. Orr, M.D., President of the American Medical Association, will be the guest of honor at the annual banquet and will present an address of vital interest and concern to physicians and their wives during the banquet. Physicans who have been engaged in the active practice of medicine for 50 years will be honored at this banquet and will receive certificates of distinction. Montana physicians who will be so honored will be E. M. Adams, M.D., Red Lodge; Lindsey W. Baskett, M.D., Big Timber, and C. L. Bourdeau, M.D., Missoula.

On Friday evening, September 18, physicians and guests attending the Annual Meeting will be entertained by the members of the Silver Bow County Medical Society.

Eighty-First Annual Session

of the

Montana Medical Association

September 17, 18, 19, 1959 . . . Butte, Finlen Hotel

Note: All Scientific and Business Meetings will be held in the Silver Bow Room of the Finlen Hotel.

Thursday, September 17

Morning

10:00—Welcome, Roger W. Clapp, M.D., President, Silver Bow County Medical Society. Response, Herbert T. Caraway, M.D., President, Montana Medical Association.

10:15—"How Much Does the Unconscious Patient Hear?", David B. Cheek, M.D., Clinical Instructor in Gynecology, University of California Medical Center.

10:40—"Clinical Use of Filter Paper Electrophoresis," John R. Walsh, M.D., Professor and Director, Department of Medicine, Creighton University School of Medicine.

11:05—"The Acute Surgical Abdomen in Infancy and Childhood," Charles W. McLaughlin, Jr., M.D., Professor of Surgery, University of Nebraska College of Medicine.

11:30—"A Practical Approach to Growth Retardation," John R. Connell, M.D., Medical Director, The Children's Hospital, Denver.

Afternoon

1:30—"Farm Injuries," Charles W. McLaughlin, Jr., M.D.

1:55—"Recurrent Urinary Infections in Childhood," Clarence V. Hodges, M.D., Professor of Surgery and Head of the Division of Urology, University of Oregon Medical School.

2:20—"Diabetes Mellitus and the Eye," Frank W. Newell, M.D., Professor of Surgery and Chairman, Section of Ophthalmology, The University of Chicago.

3:25—"How Steroid Hormones Inhibit Inflammation," Thomas F. Dougherty, Professor and Head of Department of Anatomy, University of Utah College of Medicine.

4:10—"Treatment of Leukemia," John R. Walsh, M.D.

Friday, September 18

Morning

9:35—"Surgical Diseases of the Spleen," Charles W. McLaughlin, Jr., M.D.

10:00—"Common Foot Deformities in Children," John H. Moe, M.D., Clinical Professor of Orthopedic Surgery, University of Minnesota Medical School.

10:45—"Staphylococcal Disease in Childhood," John R. Connell, M.D.

11:10—"A Survey of Collagen Diseases," John R. Walsh, M.D.

Afternoon

1:45—"Should We Know More About Hypnosis?", David B. Cheek, M.D.

2:10—"Ureteral Injuries," Clarence V. Hodges, M.D.

2:35—"What Is Meant by 'Stress' and How Hormones Influence It," Thomas F. Dougherty, Ph.D.

Saturday, September 19

Morning

9:15—"Prevention and Treatment of Bone Infections," John H. Moe, M.D.

9:40—"Regimen for Management of Kidney Failure," Clarence V. Hodges, M.D.

10:05—"Use of Hypnosis in Preparing the Obstetrical Patient for Delivery," David B. Cheek, M.D.

11:00—"The Peripheral Blood Smear in Pediatric Diagnosis," John R. Connell, M.D.

11:25—"Diagnosis and Treatment of Low Back Pain," John H. Moe, M.D.

Abstract of Minutes*
House of Delegates
New Mexico Medical Society

77th Annual Meeting
May 4, 1959
Las Cruces, N. M.

FIRST SESSION

May 4, 1959—9:00 a.m.

President James C. Sedgwick, M.D., called the House to order at 9:00 a.m., in Milton Hall, New Mexico State University.

Secretary-Treasurer Omar Legant, M.D., called the roll of Delegates and vouched for the credentials of the Delegates present, declaring that a quorum was present.

The minutes of the Interim House of Delegates' meeting were approved, as published in the Rocky Mountain Medical Journal.

The President introduced John Zarit, M.D., President, Colorado State Medical Society, who expressed his appreciation for being present as a Fraternal Delegate to our meeting and urged the Delegates to attend the Rocky Mountain Medical Conference, which will be held in Denver on September 8-11. Dr. Zarit expressed the seriousness of the business coming before the House of Delegates of State Medical Societies and urged the House to "find the facts, filter the facts, form the facts, and face the facts."

M. D. Thomas, M.D., Fraternal Delegate from Texas, was introduced by Dr. Sedgwick. Dr. Thomas addressed the House, discussing certain business which had come before the House of Delegates of the Texas Medical Association just two weeks previously. Dr. Thomas urged the members of the New Mexico Medical Society to attend the A.M.A. Clinical Session in Dallas in December, and also to attend the Annual Meeting of the Texas Medical Association in Fort Worth in 1960.

The President informed the House that Mr. Harvey Sethman, Executive Secretary of the Colorado State Medical Society, was absent for the first time in 26 Annual Meetings of the New Mexico Medical Society, and that Mr. John Pom-

continued on page 102

*Condensed from the shorthand record of Mrs. Ralph Marshall, reporter. Records referred to but not reproduced herein were distributed to all members of the House of Delegates at the Annual Meeting in the mimeographed Handbook, or were distributed to all members of the House in mimeographed form at the opening session. Copies of such reports are on file in the executive offices of the Society and are available for study by any member of the Society.

Organization cont. from page 99

pelli, Mr. Sethman's able assistant, would report concerning the Rocky Mountain Medical Journal.

Mr. Pompelli informed the House that the Journal was in excellent shape financially, and that it would continue to be necessary to run the Journal with a ratio of 60 per cent advertising and 40 per cent editorial material until such time as the members contributed more scientific material to the Journal. He stated that they were continuing to improve the publication design-wise and were doing their best to provide a readable Journal, which competes with the best-designed and written material in the country.

Mr. Pompelli pointed out that the Rocky Mountain Cancer Conference would be held in July and invited all members to attend. Mr. Pompelli expressed appreciation to Aaron Margulis, M.D., our Scientific Editor from this state, for the wonderful assistance he has given to the Journal during his tenure as Scientific Editor.

The President asked Mr. Rueben Dalbec, A.M.A. representative for this region, to stand and informed the House that Mr. Dalbec was attending our meeting for the purpose of being of assistance to anyone and to become better acquainted.

The President announced the appointment of his three reference committees, as follows:

Reference Committee on Published Reports: Allan L. Haynes, M.D., Chairman; John D. Abrums, M.D.; S. W. Adler, M.D.; Owen C. Taylor, M.D.; James L. McCrory, M.D.; R. C. Derbyshire, M.D.; Albert M. Rosen, M.D.

Reference Committee on Reports of Officers and Council: Guy E. Rader, M.D., Chairman; Frank A. Rowe, M.D.; Thomas L. Carr, M.D.; John Boyd, M.D.; John Corcoran, M.D.; Howard Seitz, M.D.; L. J. Whitaker, M.D.

Reference Committee on Miscellaneous Business: Samuel R. Ziegler, M.D., Chairman; W. W. Kridelbaugh, M.D.; Karl Bergener, M.D.; John K. Torrens, M.D.; Harold Mortimer, M.D.

The President asked the House to refer to the agenda lying on the table to see the business that had been officially referred to the respective committees. The President reminded the House that at the Interim Session the House approved a resolution for the Medical Society to appoint a committee to study the pros and cons with regard to a "Relative Value Index." Dr. Sedgwick stated that he had appointed John Corcoran, M.D., of Albuquerque, to assemble information on a relative value index and report to the House. The President stated that Dr. Corcoran had done a great deal of research and had attended a regional meeting in San Francisco this past month on this very subject, and called on Dr. Corcoran for an oral report.

Dr. Corcoran presented a lengthy report on the subject, and then introduced the following resolution:

Resolution

WHEREAS, There is a need for a schedule of Relative Values, which may be referred to by physicians, insurance companies, federal, state, union and welfare organizations, dealing with medical fee schedules;

WHEREAS, It is believed that such values have been and will be determined by parties who are not qualified and do not have the interest of physicians always in mind;

WHEREAS, Only practicing physicians are truly cognizant of proper medical relative values; therefore, be it

RESOLVED, That the New Mexico Medical Society develop and publish a Relative Value Index.

The President referred this resolution to the Reference Committee on Miscellaneous Business.

The President recognized Roy Goddard, M.D., Chairman, Public Health Committee, for a supplementary report, which was referred to the Committee on Published Reports, after having been mimeographed and presented to each Delegate.

The President informed the House of Delegates that the Chairman of the Advisory Committee to the Welfare Department, Allan Haynes, M.D., and our Executive Secretary, had personally visited the states of Washington and Nevada for the purpose of reviewing the program those medical societies have in which they administer the medical program of their respective welfare departments. The President called on Allan Haynes, M.D., for a supplemental report concerning the results of this personal investigation of these two plans.

Supplemental reports

Dr. Haynes went into detail, explaining each of these state's programs, in which the amount of care furnished to welfare clients is purposely limited and in no way compares to our comprehensive program in this state. Limitation of services is carefully spelled out in each program and enforced in practice to insure that only "emergency" and "necessary" care is paid for by these programs. Dr. Haynes pointed out that the common denominator in both plans is certainly the legislative intent to limit care to urgent and necessary treatment. He reported that an impressive argument was presented, and physicians' generosity in granting services for less than usual fees had encouraged loose administration and poor control of funds and services, so that ultimately,

funds are not available to provide the minimum and necessary care that the recipients are entitled to by law and social conscience. The conclusion drawn was that a disciplined generosity may be more effective in the long run and, therefore, more charitable than an uncontrolled one.

It is the opinion of the committee that no attempt should be made to enter into a contractual arrangement for payment of medical services by this Society at this time. It is the committee's further opinion that no reasonable and effective program can exist in this state until the scope or limitations of the Medical Care Program had been clearly established—preferably by legislative definition.

Recommendations: "In view of the fact that a new Director is expected to take office in the D.P.W., this committee should first ascertain if the Department plans to bring out a definite program for welfare medical care, and whether such a program is reasonable in the opinion of this Society. If no such program is forthcoming in a reasonable time, this committee should be authorized to develop a satisfactory program aimed for legislative enactment; this committee, with the Public Relations Committee, should, by proper publicity, develop public interest and support for the proposed legislation."

The President commended Dr. Haynes for the splendid report and referred his supplementary report to the Committee on Published Reports.

John Abrums, M.D., Chairman of the Medical-Legal Committee, gave an oral supplemental report informing the House that the committee had revised the Code of Mutual Conduct with the Bar Association, and the material, as now revised, will be made available to the reference committee. Improvements have been offered in the disability insurance program of the Society, and the House of Delegates will decide whether to authorize that this insurance program be reopened.

The President referred this supplemental report to the Committee on Published Reports.

John Boyd, M.D., Chairman, AMEF Campaign, reported that he has been approached by the State Pharmaceutical Association to officially ask the House of Delegates' approval of the pharmacists making contributions to the AMEF on behalf of doctors at Christmastime, instead of remembering physicians with personal gifts.

The President referred this supplemental report to the Committee on Published Reports.

C. P. Bunch, M.D., Chairman, Constitution and By-laws Committee, offered the following supplemental report, or amendments to the published report in the Handbook:

(1) Article VI, Section 1, following the word "speaker," be added "and Vice Speaker." (2) That Article VI, Section 2, be revised, as follows: Add following "Secretary-Treasurer," the words

"Speaker and Vice Speaker." (3) Dr. Bunch pointed up that there was a typographical error under "By-Laws Amendments," and requested that Chapter VI be changed to Chapter XI.

The President referred the supplemental report to the Reference Committee on Published Reports.

The President called for new business.

New business

Stuart W. Adler, M.D., introduced the following resolution:

EXPLANATION: The Medical Advisory Committee of the New Mexico Chapter of the National Foundation (formerly NFIP) has requested approval by the medical profession in the state, of certain of its planned activities for the next several years. This request was directed to the State Society's Liaison Committee with the Voluntary Health Organizations. Since no formal action has been taken on the matter by the committee, its Chairman is requesting that the House of Delegates receive and consider the following resolution:

Resolution

BE IT RESOLVED, That the New Mexico Medical Society give approval to the survey study of New Mexico of the National Foundation as publicly announced, including the review of status of poliomyelitis patients and certain other conditions found through the records of public agencies, appropriate clinics, and through physicians desiring to cooperate.

The President referred this resolution to the Committee on Published Reports.

Sol Heinemann, M.D., Delegate from Eddy County, was recognized for the purpose of introducing the following resolutions:

Resolution

BE IT RESOLVED, That the New Mexico Medical Society adopt a firmer stand in support of the free choice of physician in any future actions than that action taken by the Council November 21, 1953.

The President referred this resolution to the Reference Committee on Officers and Council Reports.

Resolution

BE IT RESOLVED, That the New Mexico Medical Society consider a medical malpractice arrangement, similar to the one now in use in Massachusetts.

The President referred this resolution to the Committee on Miscellaneous Business.

Hyman Bashein, M.D., Delegate from the Tri-County Medical Society, informed the House that his Society would like the House of Delegates' consideration in the possibility of establishing a medical school in New Mexico and yielded to Tom Carr, M.D., Delegate from Bernalillo County, for the purpose of introducing a resolution from that Society, supporting this principle:

Resolution

BE IT RESOLVED, That the Bernalillo County Medical Association requests an investigation by the American Medical Association's Liaison Committee of New Mexico's problems in medical education. Such investigation would be designed to determine:

1. Needs as they now exist.
2. Needs predicated for the next 20 years.
3. Facilities available for us in a medical education program.
4. The type of program most favorable to the needs found.

The President then informed the House that Mr. Tom Popejoy, President of the University of New Mexico, had called him and had forwarded a letter requesting that the House of Delegates approve a study to determine the feasibility of a two-year medical school.

The President referred the above resolution and letters from Mr. Popejoy to the Reference Committee on Officers and Council Reports.

Charles R. Beeson, M.D., introduced the following resolution:

Resolution

BE IT RESOLVED, That the New Mexico Medical Society support the report of the Governor's Committee on Mental Hygiene of 1958, and that the Committee on Mental Health of the State Medical Society investigate this problem and report to the next meeting of this House.

The President announced that this resolution would be referred to the Committee on Miscellaneous Business.

There being no further business to come before the House, the President declared the House in Recess until 3:00 p.m., for the purpose of holding reference committee hearings.

SECOND SESSION

May 4, 1959—3:00 p.m.

President Sedgwick called the House to order and after a roll call by the Secretary-Treasurer, who declared a quorum to be present, announced the Second Session ready for the transaction of business.

The President recognized John Boyd, M.D.,

Chairman, AMEF. Dr. Boyd informed the House that Mr. Charles Pineau and Mr. Ralph Gutierrez of the Dona Ana Pharmaceutical Association were present to make a contribution from the Dona Ana pharmacists to the AMEF.

Dr. Boyd expressed the deep appreciation of the members of the medical profession for this gift from the pharmacists to the AMEF.

The President appointed the following Tellers for the election: Paul Feil, M.D., Chairman; Richard Walsh, M.D.; Robert Boice, M.D., and W. K. Woodard, M.D.

C. P. Bunch, M.D., Chairman of the Nominating Committee, was recognized for the purpose of giving his report. The Nominating Committee report, as presented and as submitted in written form in the Handbook, was received without change.

Dr. Brunch reported that Warren Hall, M.D., of Silver City, had moved out of the state, and that it would be necessary to elect someone to serve on the Grievance Committee in Dr. Hall's place. Richard Walsh, M.D., Silver City, and Ezra Neidich, M.D., Las Cruces, were nominated.

The President stated that the Nominating Committee had not nominated members to succeed themselves and, therefore, nomination for members on the Nominating Committee were ordered. Nominations were received from the floor for the seven offices to be filled.

The President instructed the Tellers to collect the ballots and to report back to the House as soon as they had completed the count. The President called on Allan Haynes, M.D., Chairman of the Reference Committee on Published Reports, for his report.

Report of the Reference Committee on Published Reports

1. This committee approved the annual report of the American Medical Education Foundation Committee, as published in the Handbook, and moved that this portion of the report be approved. Motion was duly seconded and carried.

2. The committee approved the annual report of the Adjudication Committee, and the Chairman moved that this portion of the report be accepted. Motion was duly seconded and carried.

3. The committee recommended acceptance of the report of the Committee on the Problems of Aging, with the following revision:

"The report suggests that possibly there should be a representative on this committee from the Welfare Department, and it was suggested that the administrative head of the department be considered for appointment to this committee. The committee recommends that this committee be made up exclusively of members of this Society and that all other personnel be asked to serve in an advisory capacity." The Chairman moved that the committee report on the Problems of the Aging, with the revision, be approved. Motion was seconded and carried.

4. The reference committee recommended that the Maternal and Infant Mortality Committee report be amended, as follows:

a. Under Recommendation No. 1—The committee recommends that the word "directed" be changed to read "requested."

b. The committee suggests that to Item No. 3 of the recommendations, be added the following sentence: "Before the next legislative year, that the State Society attempt to carry into effect the spirit of Senate Bill No. 92."

Dr. Haynes moved that the Maternal and Infant Mortality Committee's report, as amended, be approved. Motion was duly seconded and carried.

5. The committee recommends the following with reference to the report of the Medical-Legal Committee:

a. That if further negotiations with the Arizona Industrial Commission are necessary, that the local County Society involved be requested to inform the State Medical-Legal Committee of its problems through a representative of that Society.

b. That the Code of Cooperation with the Bar Association, which is now available, be submitted to the officers of all County Societies, to be returned by the Delegates to the Interim Meeting of the House of Delegates.

c. That the Society authorize a re-enrollment

program for disability coverage by Washington national and commercial insurance companies.

d. That the Society approve the opening for enrollment of a disability business expense insurance program, which has been submitted to the Medical-Legal Committee by the American Casualty Company.

Dr. Haynes moved that the Medical-Legal Committee report, with the above recommendations included, be approved. Motion was duly seconded and carried.

6. The reference committee moved approval of the report of the New Mexico Physicians' Service, as published. Motion was duly seconded and carried.

7. With regard to the supplemental report of the Public Health Committee, Item 3, concerning the Advisory Committee on Radiation to the Public Health Department, the committee recommended that this be changed from "one member-at-large" to read "one other member of the New Mexico Medical Society."

Dr. Haynes moved that the supplemental Public Health Committee report, as amended, be approved. Motion was duly seconded and carried.

8. Dr. Haynes moved that the Public Relations Committee report be approved as printed. Motion was duly seconded and carried.

9. Dr. Haynes moved acceptance of the report of the Liaison Committee to the Rehabilitation Center, as published. Motion was duly seconded and carried.

10. Dr. Haynes moved that the Advisory Committee to the Department of Public Welfare's printed report and the revisions, as introduced during the morning session, be approved. Motion was duly seconded and carried.

11. Dr. Haynes moved that the Legislative Committee report, as published in the Handbook, be approved. Motion was duly seconded and carried.

12. Dr. Haynes moved that the report of the Grievance Committee be approved as published in the Handbook. Motion was duly seconded and carried.

13. Dr. Haynes moved that the report of the New Mexico Medical Society's Representative to the Tuberculosis Coordinating Committee be approved, as published in the Handbook. Motion was duly seconded and carried.

14. With regard to the published report of the Liaison Committee to the Allied Professions, the committee recommends that Item No. 2 of the suggestions be deleted. Dr. Haynes moved that the published committee report, as amended, be approved. Motion was duly seconded and carried.

15. With regard to the resolution introduced by Dr. Adler, concerning the National Foundation, your committee recommends that the second paragraph be changed to read as follows:

BE IT RESOLVED, That the New Mexico Medical Society give approval to the survey-study in New Mexico of the National Foundation, as publicly announced, for review of the status of poliomyelitis patients found through the records of public agencies, appropriate clinics, and through physicians desiring to cooperate.

Dr. Haynes moved this resolution, as amended, be approved. Motion was duly seconded and carried.

16. With regard to the published report of the Constitution and By-Laws Committee and the supplemental amendments introduced at the morning session, the Chairman of the reference committee moved that this report, with amendments, be approved. Motion was duly seconded and carried.

17. The Chairman of the reference committee, Dr. Haynes, then moved that the report of the reference committee, as amended and as a whole, be adopted. Motion was duly seconded and carried.

Adoption of Revised Constitution

The President reminded the House that the revised Constitution contained in the Handbook was submitted at the last Annual Meeting and had lain on the table for one year, in compliance with the Constitution, Article XV, and that he would like the House to take action on this matter at this time. It was moved that the Constitution as contained in the Handbook, and as recommended by the last House of Delegates, be approved. Motion was duly seconded and carried.

The President called on Samuel R. Ziegler,

M.D., Chairman of the Reference Committee on Miscellaneous Business, for his committee's report.

Report of the Reference Committee on Miscellaneous Business

1. Dr. Ziegler reported that his committee approved the following resolution introduced by the Eddy County Medical Society:

BE IT RESOLVED, That the New Mexico Medical Society consider a medical malpractice arrangement similar to the one now in use in Massachusetts.

The reference committee recommended that this resolution be referred to the Medical-Legal Committee of the State Society for investigation, with instructions to report its findings to the Interim House of Delegates Meeting.

Dr. Ziegler moved that this portion of the report be adopted. Motion was duly seconded and carried.

2. Dr. Ziegler moved that the following resolution introduced by Charles Beeson, M.D., of Bernalillo County, be approved:

BE IT RESOLVED, That the New Mexico Medical Society support the report of the Governor's Committee on Mental Hygiene of 1958, and that the Committee on Mental Health of the State Medical Society investigate this problem and report to the next meeting of this House.

Motion was duly seconded and carried.

3. Dr. Ziegler reported that the committee considered very carefully the resolution introduced by Joe Corcoran, M.D., Chairman, Relative Value Schedule.

Dr. Ziegler stated that his committee feels that this is a problem of great magnitude about which Delegates should be fully instructed by their County Societies. Therefore, the reference committee makes the following recommendation:

"That this resolution be tabled until the Interim Session of the House of Delegates. During the intervening time, the Committee on Relative Value Index be instructed to provide all County Societies with the proper material for study and instruction of its Delegates for final action at the Interim Meeting of the House of Delegates."

Dr. Ziegler moved that this portion of his report be approved. Motion was duly seconded and carried.

4. Dr. Ziegler stated that his committee had considered the "Proposed Guides for Reconciliation of Differences Within Hospital Staffs" and that the committee felt that this is a document motivated by the highest of ideals and dedicated to what is just and honest in our profession. Dr. Ziegler moved that these Guides be approved. Motion was duly seconded and carried.

5. The Chairman moved that the report of the Reference Committee on Miscellaneous Business be approved as a whole. Motion was duly seconded and carried.

The President stated that he had neglected to refer a resolution on behalf of the New Mexico Heart Association at the morning session, and,

therefore, he would like to read this resolution and to take action on it at this time, without referring it:

New Mexico Heart Association Resolution

1. WHEREAS, Engaged as we are in a great medical challenge in that the importance of cardiovascular diseases as the leading cause of deaths in the United States is increasing; and

2. WHEREAS, There is a rapidly increasing knowledge concerning the etiology, treatment and prevention of these diseases, which knowledge should be widely and quickly disseminated among physicians and auxiliary personnel;

3. WHEREAS, The accumulation of statistical data might provide an opportunity to assess epidemiological factors, educational and patient needs;

4. WHEREAS, There is an increasing realization by the medical profession of its responsibilities in fostering and developing voluntary programs to solve the problems of diseases and medical care; and

5. WHEREAS, It is the policy of the American Heart Association to foster the forming of qualified cardiovascular clinics, each clinic to "define its policies for admission of patients which shall be in accord with the accepted practices of the community"; therefore, be it

RESOLVED, That the New Mexico Medical Society second the proposal of the New Mexico Heart Association that, within the limits of the national policy just mentioned, the establishment in New Mexico of cardiovascular clinics by the physicians in various communities designed to meet the national standards of the American Heart Association and cooperating with the New Mexico Heart Associaton, be encouraged.

Andrew Babey, M.D., moved that this resolution be approved. Motion was duly seconded and carried.

The President recognized Guy E. Rader, M.D., Chairman of the Reference Committee on Officers and County Reports, for his report:

Report of the Reference Committee on Officers and Council Reports

1. Dr. Rader moved that the report of the Council's activities of February 21, 1959, be approved, without change. Motion was duly seconded and carried.

2. With regard to the Council report, dated May 2, 1959, the committee recommends the following amendments:

a. Item 4: Add: "The Council be instructed that in the future, monies be allocated annually in the budget toward purchase of a Society-owned automobile."

Dr. Rader moved the acceptance of this portion of the report. Motion was duly seconded and carried.

b. Item 10: The committee recommends that the action of the Council be disapproved, inasmuch as it may be contrary to the provisions of the State Constitution. However, the committee recommends that the House of Delegates instruct the Constitution and By-Laws Committee to investigate and prepare proper revisions of the Constitution and By-Laws to recognize physicians in the State who may not be fully licensed and to designate their membership, rights and privileges.

Dr. Rader moved acceptance of this portion of his report. Motion was duly seconded and carried.

At this point, Dr. Rader requested the privilege of having C. P. Bunch, M.D., Chairman of the Constitution and By-Laws Committee, make some explanatory comments to the House. Dr. Bunch pointed out that under our present Constitution and By-Laws, requirements for membership provide a physician must be of good moral character and licensed by the New Mexico Board of Medical Examiners. This committee has been informed that certain physicians who have a permit to practice in an institution in this state do not have a regular New Mexico license. Because of this, it was felt that the Council's action, which the House disapproved, would be unconstitutional. Dr. Bunch submitted to the House two possible solutions to this problem for the members' consideration prior to the Interim Meeting of the House of Delegates, as follows:

"Physicians of good moral character, graduates of a medical school, residing in the state, who are employed by the Federal Government, or who have been issued a permit by the New Mexico Board of Medical Examiners, to practice in a state institution, or to engage in limited practice, may apply for membership as regular members."

As an alternative: "Associate membership, with limitations."

3. With regard to Item 17 in the Council report, the committee recommends an amendment as follows:

In line 2, delete the word "invited" and substitute the words "requested and urged."

In line 3, following the word "By-Laws" insert "by January 1, 1960."

Dr. Rader moved that this portion of the report be accepted. Motion was duly seconded and carried.

4. Dr. Rader moved that the House of Delegates approve the amended report of the Council, dated May 2, 1959. Motion was duly seconded and carried.

5. The committee recommended that the report of the Delegates to the A.M.A., as published in the Handbook, be approved. Motion was duly seconded and carried.

6. The reference committee recommended that the House of Delegates disapprove the resolution introduced by the Eddy County Medical Society, which directed the Council to take a firmer stand on the position of free choice of physician in the future.

Dr. Rader moved the acceptance of this portion of the report. Motion was duly seconded and carried.

7. Dr. Rader moved the acceptance of the reference committee's report as a whole. Motion was duly seconded and carried.

Frank Rowe, M.D., Delegate from Bernalillo County, was recognized and pointed out that the Council report, dated February 21, 1959, states that the House of Delegates had been asked to consider the advisability of discontinuing the publication of the Newsletter, and that the material usually published in same be forwarded for publication in the Rocky Mountain Medical Journal. Dr. Rowe stated that he was a member of the Reference Committee on Council and Officers Reports, and it was the opinion of the committee that the Newsletter should not be discontinued and should be continued in its present form and that this portion of the Council's report should be rejected. Dr. Abrums moved that the Newsletter be continued. Motion duly seconded and carried.

Election Results

The President recognized Paul Feil, M.D., Chairman of the Tellers Committee, for a report.

Dr. Feil submitted the following election results:

President-elect: Allan L. Haynes, M.D.

Vice President: William Badger, M.D.

Secretary-Treasurer: T. L. Carr, M.D.

Councilor, District II: W. R. Oakes, M.D.

Grievance Committee: Joe Norman, M.D.; Richard Angle, M.D.; Joseph Sharpe, M.D.; E. K. Neidich, M.D.

Convention Site Committee: Robert Boice, M.D.; Albert Lathrop, M.D.; C. M. Thompson, M.D.

New Mexico Physicians' Service Board: Allan Haynes, M.D.; Emmit Jennings, M.D.; Clarence Kaiser, M.D.; H. O. Lehmann, M.D.; W. L. Minton, M.D.

Convention Scientific Program: Andrew Babey, M.D. (3 years); A. E. Margulis, M.D. (3 years); Roy Goddard, M.D. (2 years); Burgess Gordon, M.D. (2 years); Martin Goodwin, M.D. (1 year); Earl Flanagan, M.D. (1 year).

Nominating Committee: District I, Harold Mortimer, M.D.; District II, H. R. Landmann, M.D.; District III, S. W. Adler, M.D.; District IV, George Prothro, M.D.; District V, Sol Heinemann, M.D.; District VI, Leland Evans, M.D.; District VII, Wendell Peacock, M.D.

Dr. Feil indicated that there was a tie vote for Councilman from District I, between Drs. R. P. Beaudette and J. J. Johnson, Jr.

The President instructed that ballots be cast for a run-off election for Councilor for District I.

Dr. Feil reported that as a result of the election run-off for position of Councilor for District I, R. P. Beaudette, M.D., of Raton, was elected.

The President announced that he would now entertain nominations from the floor for the position of Speaker of the House of Delegates, and Vice Speaker. C. P. Bunch, M.D., was nominated and was elected Speaker of the House of Delegates by acclamation.

R. C. Derbyshire, M.D., of Santa Fe, was nominated and elected Vice Speaker of the House by acclamation.

The retiring President, James C. Sedgwick, M.D., expressed his sincere thanks to the members of the Council, committee chairmen and all members of the committees who have willingly served throughout the year, and wished for his successor,

continued on page 112

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Organization cont. from page 109

Lewis M. Overton, M.D., all of the cooperation and respect that he had received in his year as President.

The President appointed two of the Society's Past Presidents, Drs. Samuel R. Ziegler and Earl Malone, to escort the new President, Lewis M. Overton, M.D., to the rostrum.

Dr. Overton thanked the Delegates for electing him to this high honor and for the confidence bestowed in according him this honor. He assured the Delegates that he would do everything in his power to uphold their confidence. Dr. Overton stated that he has chosen the theme for this year as, "Where are we, why are we here, where are we going, and what can we do about it?" Dr. Overton pointed out that he was of the opinion that medicine is definitely at the crossroads today, so far as the future is concerned. It will be necessary to take a positive stand, if we are going to maintain our economy, and, using the words of Ben Franklin, he quoted: "We must all hang together, or we will hang separately."

He stated that he would be visiting county societies this fall and that he planned to have the Councilor of each District visit the societies in his area with him.

Dr. Overton announced that the 1960 Annual Meeting of the New Mexico Medical Society will be held at the new Western Skies Hotel in Albuquerque, May 10-13.

Guy E. Rader, M.D., moved that the House of Delegates give a rising vote of thanks to the outgoing President, Dr. Sedgwick, for a job well done this past year. A hearty rising vote and applause followed.

Samuel R. Ziegler, M.D., introduced the following resolution:

Resolution

WHEREAS, This is a state meeting sponsored by the State Society; and

WHEREAS, The majority of work falls on the shoulders of the local County Medical Society; therefore, be it

RESOLVED, That this Society and the House of Delegates go on record as expressing its appreciation to doctors in Dona Ana County Medical Society for their gracious hospitality.

A hearty ovation followed.

There being no further business, the 77th Annual Session of the New Mexico Medical Society adjourned without day.

OMAR LEGANT, M.D.,
Secretary-Treasurer.

care prepayment plans. Each of these programs, whether sponsored by industry, labor, consumer groups or private insurance companies, has its merits. But none of them is committed—as Blue Shield is—to guidance by our profession. If any or all these other agencies were to gain predominance in the medical care prepayment field, then our profession would no longer control the basic economy of medicine and the pattern of medical practice.

Blue Shield is the largest single factor in medical care prepayment today. It is making payments to physicians for services rendered Blue Shield patients at the rate of more than half a billion dollars a year, and nearly one-quarter of all the people in America are Blue Shield members.

Blue Shield is big because medicine has a big job to do, and the people of America evidently like the way we're trying to do it. Blue Shield is big business—but it can't go anywhere without our help and guidance.

Voluntary health agency gives scholarships

Nearly 1,100 young people seeking to enter medical schools in September, 1959, have applied for one of the 103 medical student scholarships offered by The National Foundation under its recently announced Health Scholarship program.

Dr. Catherine Worthingham, Director of the Department of Professional Education of this voluntary health agency, said more than 4,600 applications were received from students seeking financial assistance to enter the health field. In addition to students seeking help to enter medical schools, approximately 2,500 young people sought to enter schools of nursing, 500 to enter physical therapy, 200 to enter medical social work, and 300 to enter schools of occupational therapy.

Successful applicants in each state will be chosen by special Health Scholarship Selection Committees composed of representatives of the five health professions concerned. State medical societies cooperated in nominating doctors who would represent their specific discipline.

The committees will have selected the scholarship winners between June 15 and July 15. Winners of the awards will be notified early in August by the chairman of the local National Foundation chapter in the area in which the student lives.

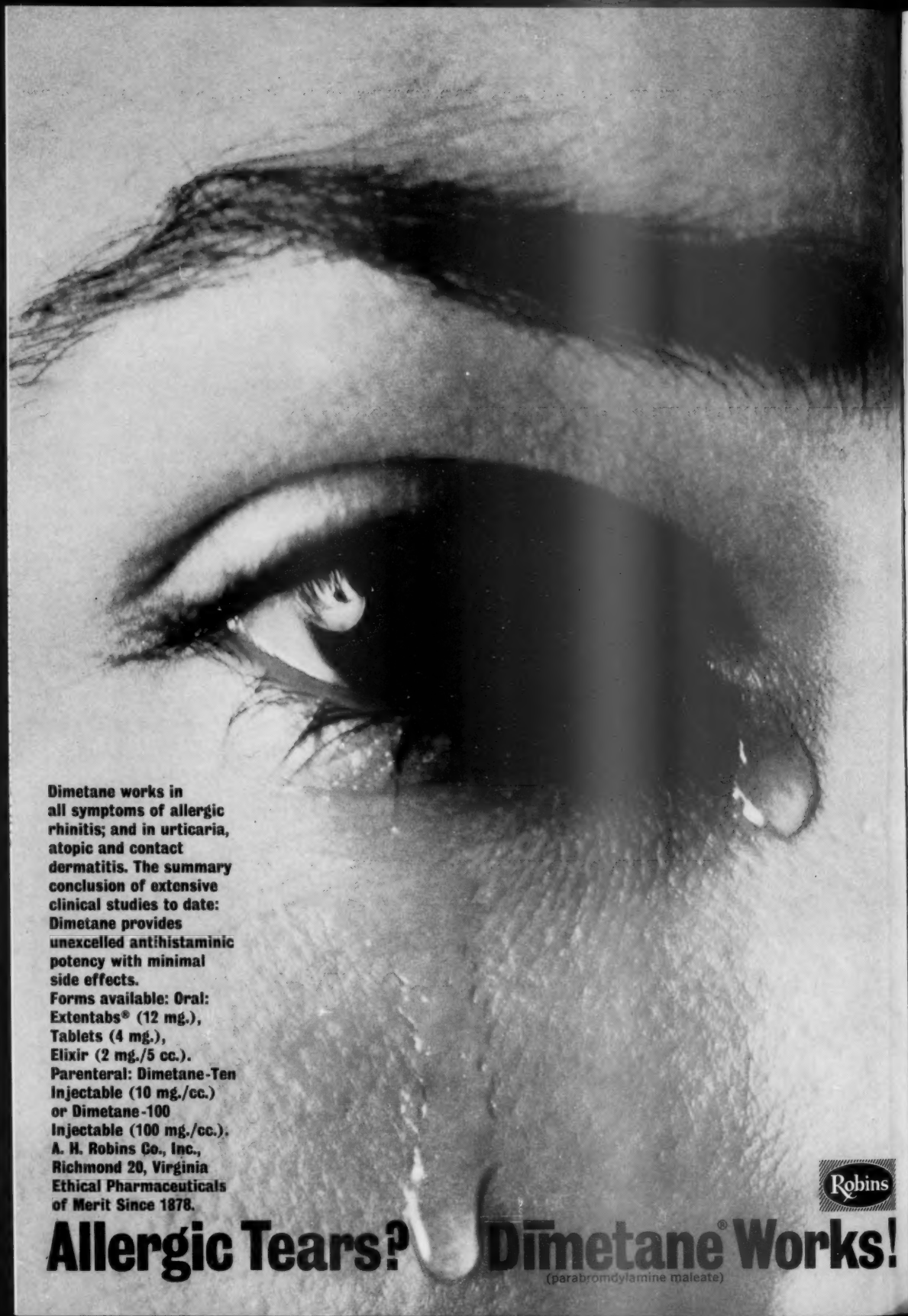
The health scholarships, which provide $2,000 for four years of college education for each recipient, are a part of the total expanded program of The National Foundation, the objectives of which are: to extend the frontiers of research and patient aid developed in the conquest of poliomyelitis, to other disabling diseases. After years of study and planning, The National Foundation selected arthritis and congenital malformations of the central nervous system as the logical first steps to accomplish these goals.

Through scholarship assistance to over 500 young people annually, The National Foundation will add to the total number of professional persons in the nation and, through continued support for graduate and postdoctoral study, will assist in the preparation of additional research scientists, teachers, and clinical specialists so necessary to the attainment of any health objective.

The National Foundation Health Scholarship program is supported by the New March of Dimes.

Annual Meeting of Ultrasonics in Medicine

The American Institute of Ultrasonics in Medicine will hold its Annual Meeting on September 2, 1959, at the Leamington Hotel, Minneapolis, Minnesota. The guest speaker at the luncheon meeting will be Russell Meyers, M.D., Professor of Surgery and Chairman, Division of Neurosurgery, State University of Iowa Hospitals and College of Medicine, who will discuss, "The Potentials of Ultrasonics in General Surgery and Surgical Specialties." For any further information, contact John H. Aldes, M.D., Secretary, 4833 Fountain Avenue, Los Angeles 29, California.



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CHILDREN: ½ teaspoon (=2.5 cc.) per 15 lb. of body weight every four hours day and night until stools are reduced to five daily, then every eight hours for three days.

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THE BOOK CORNER

New books received

New books received are acknowledged in this section. From these, selections will be made for reviews in the interests of the readers. Books here listed will be available for lending from the Denver Medical Library soon after publication.

Textbook of Pediatrics: Edited by Waldo E. Nelson, M.D., D.Sc. 7th edition. Philadelphia, W. B. Saunders Co., 1959. 1462 p. Price: $16.50.

An Atlas of Normal Radiographic Anatomy: By Isadore Meschan, M.A., M.D. 2d edition. Philadelphia, W. B. Saunders Co., 1959. 759 p. Price: $16.00.

Moloy's Evaluation of the Pelvis in Obstetrics: By Charles M. Steer, Med. Sc. D. 2d edition. Philadelphia, W. B. Saunders Co., 1959. 131 p. Price: $4.00.

A Way of Life; and Other Collected Writings of Sir William Osler. N. Y., Dover Publications, Inc., 1959. 278 p. Price: $1.50.

Elementary Statistics With Applications in Medicine and the Biological Sciences: By Frederick E. Croxton, Ph.D. N. Y., Dover Publications, Inc., 1959. 376 p. Price: $1.95.

Medical Radiographic Technic: Prepared by the Technical Service, X-ray Department, General Electric Co., under original supervision of Glenn W. Files. Revision by William L. Bloom, Jr., and others. 2d edition. Springfield, C C Thomas, 1959. 386 p. Price: $11.00.

Surgery of the Foot: by Henri L. DuVries, M.D. St. Louis, C. V. Mosby Co., 1959. 494 p. Price: $12.50.

Synopsis of Treatment of Anorectal Diseases: By Stuart T. Ross, M.D., F.A.C.S., F.I.C.S. St. Louis, C. V. Mosby Co., 1959. 240 p. Price: $6.50.

Book Reviews

Ciba Foundation Symposium; Amino Acids and Peptides With Antimetabolic Activity: Edited by G. E. W. Wolstenholme and Cecilia M. O'Connor. Boston, Little, Brown and Co., 1958. 286 p. Price: $8.75.

The subject matter of this book is evident from the title and was chosen as a fit subject to accompany two preceding symposia on purine and pteridine biochemistry. Because protein chemistry is so vast a subject, only one facet, antimetabolism, was chosen for this symposium.

Like its distinguished predecessors in the Ciba series, this is a presentation of papers by international authorities describing their work in related areas of research in laboratories throughout the world. The papers are enlarged upon and discussed by the participants at large following each presentation.

The main areas of antimetabolism considered herein relate to the effect of amino acid and peptide substances upon microorganisms and tumor cells. Although familiar substances such as bacitracin, antinomycin, and chloramphenicol among others are dealt with, an appreciation of this material demands concentration and deep knowledge of biochemistry. Most of the antitumor agents are still used on an experimental basis but with startlingly effective results in some cases.

continued on page 122

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References: 1. Spies, T. D., et al.: J.A.M.A. 159:645, 1955. 2. Spies, T. D., et al.: Postgrad. Med. 17:1, 1955. 3. Gelli, G., and Della Santa, L.: Minerva Pediat. 7:1456, 1955. 4. Guerra, F.: Fed. Proc. 12:326, 1953. 5. Busse, E. A.: Clin. Med. 2:1105, 1955. 6. Sticker, R. B.: Panel Discussion, Ohio State M. J. 52:1037, 1956.

Acute conditions: Two or three tablets four times daily. After desired response is obtained, gradually reduce daily dosage and then discontinue.

Subacute or chronic conditions: Initially as above. When satisfactory control is obtained, gradually reduce the daily dosage to minimum effective maintenance level. For best results administer after meals and at bedtime.

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The book corner cont. from page 116

A few of the papers treat of pure biochemistry: the stereochemistry of beta-amino acids, disulphide crosslinking in cysteine petides, etc. However, one paper in this category is of exceptional importance to basic protein chemistry in that it divulges a previously unknown property of peptides, namely, the aminoacyl insertion reaction. Through this reaction, synthesis, isomerization and degration of peptide chains are possible without the breaking of those chains. Previous chemistry involving reactions upon the peptide linkages left natural processes obscure. The rewarding result of this discovery should be a clarification of natural protein phenomena by in vitro methods. As with all of the Ciba Foundation Symposia, this book is a welcome asset to the shelves of our medical library as a portal through which we may view the brilliant present of biochemical research together with the beckoning of the future.

Richard Kellar, M.D.

Fundamentals of Otolaryngology: By Lawrence R. Boies, M.D. 3d edition. Phila., W. B. Saunders Co., 1959. Price: $8.00.

The third edition of Boies' Textbook, like its predecessors, adheres to the author's original purpose of offering fundamental information to the undergraduate medical student. This it does rather uniquely and adequately by discussing the subject

matter under such headings as: hearing loss, vertigo, tinnitus, chronic nasal obstruction, dysphagia, etc. Although this book is also intended for the physician who is not a specialist in otolaryngology, such a physician is apt to find its format less to his liking because the usually accepted disease entities are not discussed as such. Conidering that over 25 per cent of the generalist's patients will come in with ear, nose or throat complaints, he should have access to a text lending itself to more ready reference. Nevertheless the book is thoroughly up to date, having kept apace with most of the newer concepts of the rapidly changing field. It laudibly advocates medical management of diseases before resorting to surgical procedures which may adversely disturb normal physiology.

Bois' text should also help to reinvigorate the specialty of otolaryngology by appealing to young physicians who are seeking a field of broad scope and interest. Not only is pure otolaryngology depicted, but there is also included allergy, bronchoesophagology, maxillo-facial usrgery, and head and neck surgery as its legitimate fields. Admittedly, because of these numerous activities, it would be difficult for anyone to be entirely competent in all phases of such a specialty. In reality it thereby appears to advocate fragmentation of otolaryngology into specialties within a specialty.

Herman J. Laff, M.D.

Treatment in Internal Medicine: By Harold Thomas Hyman, M.D. Phila., J. B. Lippincott Co., 1958. 609 p. Price: $12.50.

This work admirably succeeds, within the bounds of reasonable size, in providing up-to-date information on the therapy of the diseases, both common and exotic, which are likely to be encountered in a medical practice. The author's viewpoint is that of a physiologically-oriented internist, who presents a distillate of the mass of information available on the management of nonoperative problems. For each type of illness, the author, who produced the enthusiastically received "Handbook of Differential Diagnosis," gives a rational approach to practical management—both the useful diagnostic maneuvers as well as a detailed and documented therapeutic plan. The text is liberally sprinkled with useful tables and references to pertinent literature, which make it not only one man's system of practice but also a source for further information on each subject. Extra features, not found in the more conventional "Therapies" sired by large series of collaborating authors, include: details on how to carry out specific procedures, pros and cons for a multitude of drugs and regimens, and division of treatment programs into those suitable for generalist and specialist management.

I found the book helpful in actual practice, using it to check on my management of office and hospital patients for several weeks. I am certain it would be even more useful to the new physician and house officer. Marshall A. Friedman, M.D.

Postgraduate course in Advanced Electrocardiology

The University of Nebraska College of Medicine will offer the first of a 10-course series of postgraduate programs September 28, 29 and 30. Dr. Enrique Cabrera, of the Institute of Cardiology in Mexico City, will team with Dr. Eugene Lepeschkin of the University of Vermont to present the three-day course in Advanced Electrocardiology. The course fee will be $50.00. Application should be made to: Office of Medical Extension, University of Nebraska College of Medicine, 42 and Dewey, Omaha 5, Nebraska.

The Colorado State Medical Society

Rocky Mountain Medical Conference, September 8-11, 1959
Denver

President: John I. Zarit (Chairman of the Board), Denver.
President-elect: John L. McDonald, Colorado Springs.
Vice President: Robert P. Harvey (Vice Chairman of the Board), Denver.
Treasurer: William C. Service, Colorado Springs, 1959.

Constitutional Secretary: Harry C. Hughes, Denver, 1960.
Additional Trustees: Bernard T. Daniels, Denver, 1959; Carl W. Swartz, Pueblo, 1960; Fred R. Harper, Denver, 1961; Walter M. Boyd, Greeley, 1961.

Delegates to A.M.A.: Kenneth C. Sawyer, Denver, 1960; (Alternate, Gatewood C. Milligan, 1959); E. H. Munro, Grand Junction, 1959; (Alternate, H. E. McClure, Lamar, 1959); I. E. Hendryson, Denver, 1959; (Alternate, C. C. Wiley, Longmont, 1959).

Executive Secretary: Mr. Harvey T. Sethman, 835 Republic Building, Denver 2, Colorado; Telephone AComa 2-0547.

Montana Medical Association

Annual Meeting, September 17-19, 1959
Butte

President: Herbert T. Caraway, Billings.
President-elect: Leonard W. Brewer, Missoula.
Vice President: Raymond F. Peterson, Butte.
Secretary-Treasurer: W. E. Harris, Livingston.
Assistant Secretary-Treasurer: Jess T. Schwidde, Billings.

Executive Committee: Herbert T. Caraway, Billings; Leonard W. Brewer, Missoula; Raymond F. Peterson, Butte; W. E. Harris, Livingston; John A. Layne, Great Falls; Edward S. Murphy, Missoula.

Delegate to American Medical Association: Paul J. Gans, Lewiston; alternate, S. C. Pratt, Miles City.

Executive Secretary Mr. L. R. Hegland, P.O. Box 1692, Telephone 9-2585, Billings.

Nevada State Medical Association

Annual Meeting, August 19-22, 1959
Reno

President: Roland Stahr, Reno.
President-elect: Ernest W. Mack, Reno.
Secretary-Treasurer: William A. O'Brien, III, Reno.

Delegate to American Medical Association: Wesley W. Hall, Reno; alternate: Earl N. Hillstrom, Reno.

Executive Committee: Roland Stahr, Reno; Ernest W. Mack, Reno; William A. O'Brien, III, Reno; Wesley W. Hall, Reno; Earl N. Hillstrom, Reno; Stanley L. Hardy, Las Vegas; Thomas S. White, Boulder City; John M. Read, Elko; John M. Moore, East Ely; William M. Tappan, Reno.

Executive Secretary: Mr. Nelson B. Neff, P. O. Box 188, Reno; telephone FA. 3-6788.

New Mexico Medical Society

President: Lewis M. Overton, Albuquerque.
President-elect: Allan L. Haynes, Clovis.
Vice President: William E. Badger, Hobbs.
Secretary-Treasurer: Thomas L. Carr, Albuquerque.

Councilors: Wendell H. Peacock, Farmington, 1960; George W. Prothro, Clovis, 1960; Gerald A. Slusser, Artesia, 1960; W. J. Hossley, Deming, 1961; Guy E. Rader, Albuquerque, 1961; Robert P. Beaudette, Raton, 1962; William R. Oakes, Los Alamos, 1962.

Delegate to American Medical Association: Earl L. Malone, Roswell, 1960; Alternate: Samuel R. Ziegler, Espanola, 1960.

Executive Secretary: Mr. Ralph R. Marshall, 220 First National Bank Building, Albuquerque, telephone CH 2-2102.

The Utah State Medical Association

Annual Session, September 15-18, 1959
Salt Lake City

President: U. R. Bryner, Salt Lake City.
President-elect: I. Bruce McQuarrie, Ogden.
Secretary: J. Poulson Hunter, Salt Lake City.
Treasurer: Robert M. Dalrymple, Salt Lake City.

Councilors: Box Elder, 1960, D. L. Bunderson, Brigham City; Cache Valley, 1960, C. J. Daines, Logan; Carbon County, 1960, A. R. Demman, Helper; Central Utah, 1959, Stanford Rees, Gunnison; Salt Lake, 1960, Richard W. Sonntag, Salt Lake City; Southern Utah, 1960, James S. Prestwich, Cedar City; Uintah Basin, 1960, R. Bruce Christian, Vernal; Weber County, 1961, Wendell J. Thompson, Ogden; Utah, 1959, R. E. Jorgenson, Provo.

Executive Committee: U. R. Bryner, Salt Lake City, Chairman; Reed W. Farnsworth, Cedar City; I. Bruce McQuarrie, Ogden; J. Poulson Hunter, Salt Lake City; Robert M. Dalrymple, Salt Lake City.

Delegate to American Medical Association, 1957-1959: Kenneth B. Castleton, Salt Lake City; Alternate, Drew Petersen, Ogden.

Executive Secretary: Mr. Harold Bowman, 42 South Fifth East Street, Salt Lake City 2, Telephone EL. 5-7477.

The Wyoming State Medical Society

Annual Session, September 7-10, 1960
Jackson Lake Lodge

President: Benjamin Gitlitz, Thermopolis.
President-elect: Francis A. Barrett, Cheyenne.
Vice President: S. J. Giovale, Cheyenne.
Secretary: Frederick H. Haigler, Casper.
Treasurer: C. D. Anton, Cheyenne.

Councilors: Albany County, B. J. Sullivan, Laramie; Carbon County, Guy M. Halsey, Rawlins; Converse County, Roman J. Zwalsh, Glenrock; Fremont County, Bernard D. Stack, Riverton; Goshen County, O. C. Reed, Torrington; Laramie County, S. J. Giovale, Cheyenne; Natrona County, Frederick H. Haigler, Casper; Sheridan County, Ralph Arnold, Sheridan; Sweetwater County, R. C. Stratton, Green River; Teton County, Vacancy; Uinta County, J. S. Hellewell, Evanston; Northeastern Wyoming, Virgil Thorpe, Newcastle; Northwest Wyoming, John H. Froyd, Worland.

Delegate to A.M.A.: A. T. Sudman, Green River, 1960; Alternate, B. J. Sullivan, Laramie, 1960.

Executive Secretary: Mr. Arthur R. Abbey, Box 2036, Telephone 2-5525, Cheyenne.